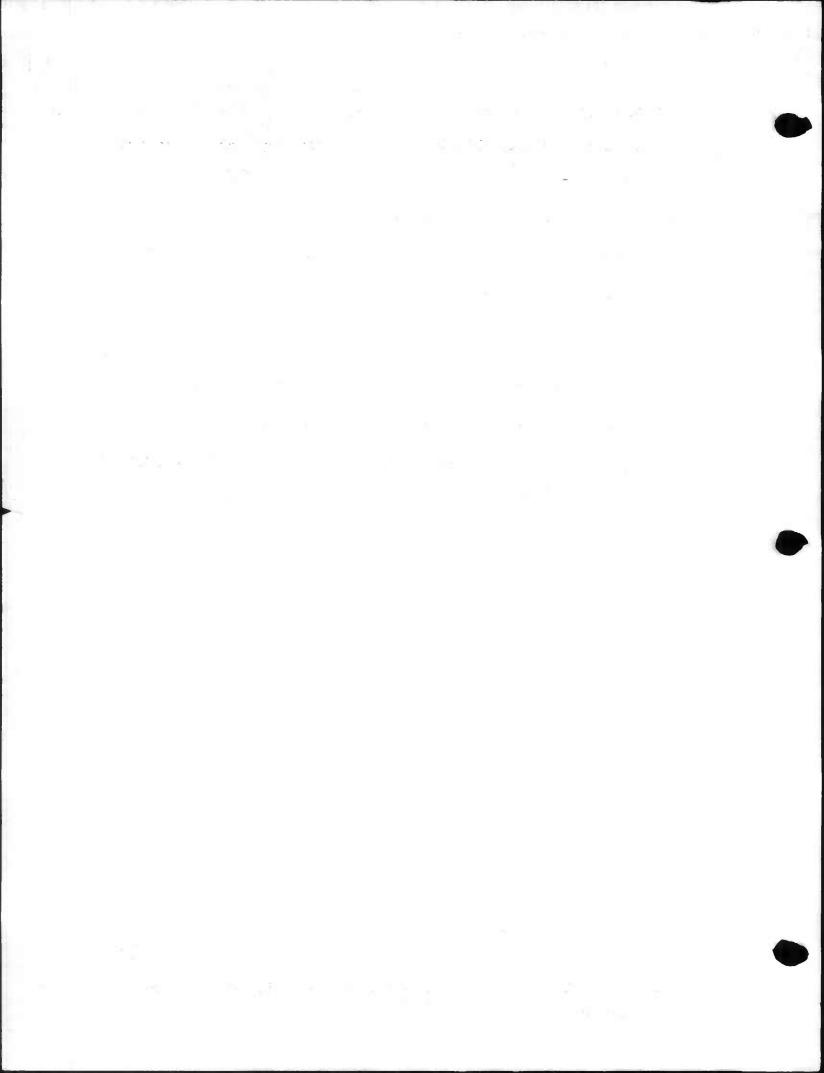
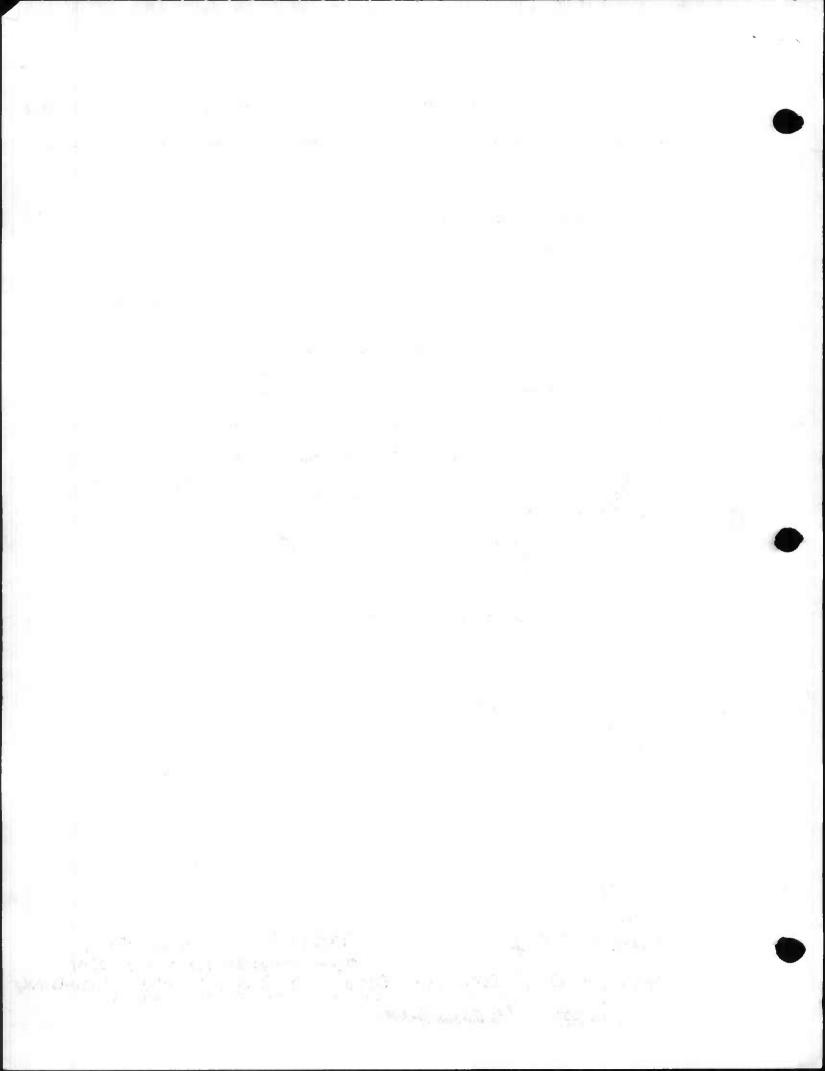
State of Maryland / Department of Health and Mental Hygiene

							$C\epsilon$	ertificat	e of	Death		Reg. No.	21	00	UUI
	Dhusiak		1. Decedent's Nam	ne (First, Middle, La	st)						2. Date of De	eath Day	Year	3. Tima	of Death
	Physicia Medic/		MARGU	ERITE	MAHADY			Н	ILL		MARCH		97	3:50	AM
	Examin		4a. Facility Name (If not institution, give	e street and number	r)				4b. City, Town, or	Location of Deat	h 4c. County	of Death		
				Center C	-				_ []	Salisbur		Wicom			
	uneral		5. Social Security N		ex 7. A □M 2⊠F	ige (In yrs. la	V	/) If Under Months	1 Year Deys			rth ay, Year)	9. Birthi	olace (State	or Foreign
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pue	ž ==	1	10a. State	10b. County		10c. City	, Town or L	ocation					1	10d. Inside	City Limits
the Maryland	E E	0	MD.	WICOM	TCO		SALI	SBURY						1 Ye	s 2 No
2	28a notil	Director	10e. Street and Nu					10f. Zlp	Code		I	10g. Citizen of N	What Cour	ntry?	
A C	38 0		705 E	AST WILLI	AM STREET				21	804		U	.S.A.		
death	natural, or leans 23s or 28s-f show dical Examiner must be notified at	Funeral	11. Maritel Stetus		12. Was Deceden	t Ever In U,S	S. 13.	. Was Deced	dent of I	Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No	o- 14. Rac	e - Americ	can Indian,	
o i	or its		1 Never Marr	ried 2 Married	Armed Forces 1 Yes 27 If Yes, Give Yeer or Dates:	No		1 Yes	37		to Hican, etc.)		ck, White,	etc. HITE	
2 2	5.0	by	3 🗆 Widowed	4 Divorced	Yeer or Dates:			1 LI Yes	2 🗆 NO	Specify:		Specify	/:		
emit. Pages 1 and 2 should be filed within 72 hours all bepartment of Health and Mental Hygiene.	"natural", idical Ex	ed	(Spe	15. Decedent'a Ec	lucation de completed)		16a. Dece	edent's Usua	el Occup	pation	rkina	16b. Kind of B	usiness/In	dustry	
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d 2 s	Item 27 is ma r other traums			ame/Relationship						t and Number or Ro			State, Zıç	Code)	
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Dall permit. Departm	Important: I any injury o		21. Signeture or Ft	uneral Service Licen	7 //	0	/	22. Name an	a Adare	ess of Facility					
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	sician ledicai		Immediate Cause	(Final	N							0	1	011001 411	
	miner		disease or condition resulting in deeth)	òn	e. //e	100	1 ce	_ c	an	een v	elm	rek.	-	MU	elle,
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ficata be ex	nysici he bu	edical	Cause (Disease or that Initiated events resulting in death)	5	C	Due to (or	as a conse	equence of):							
eath certificata be executed		Mec	rooding in doding												
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e de	hed f	Physician	Pert II. Other signi	ficant conditions of	ontributing to death	but not resul	lting in the	underiying c	ause gi	ven in Pert I.	23b. Did	tobacco use co	ntributa t	o the caus	of death?
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ling F	After	Certification:	 Manner of Deat 1 □ Natural 	5 Pending	28a. Date of Inj (Month, D	ey Year)	28b. Time Injury		8c. Inju Wo		28d. Describe	how injury occur	red		
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or Attending Physician: The law requires that the after death.	Director: J in by the	ert	4 Homicide	determined	28e. Place of Ir building, e	tc. (Specify)	ne, tarm, s	treet, factory	, OTHOR			wn, State)	er or mun	ar moure (vi	imber,
	To the Funeral Director: After completely filled in by the funer		29e. Certifier	1P Cartifying Ph	ysician: To the best	t of my know	dodgo dos	th occurred	at the ti	mo date and place	and due to the	course(s) and m		tata d	
To the Hospital within 24 hours	To the Funeral completely filled	edicai	(Check only one)	2 Medical Exam	Inar: On the basis of	of examination	on and/or in	nvestigation	in my	opinion, death occu	urred at the time,	date and place,	and due t	o the cause	e(s)
o the	omple omple	Me	29b. Signeture end	I title of certifier	, ,	2	E Sau	290	. Licens	se number		29d. Date signe	d (Month,	Day, Year)	,
F \$	-0		1	2/8	1/				00	29349	3	7/- 11	>-		
			30. Neme and addr	ess of person who	completed cause of	death /Item	23e) /Tuno			-174/		13/7	1		
1	/			ROBINS,	M D	11	04 11	PAT MUITA	1 7. V 1	DR.,SALIS	N VOITOS	יספוני ח	1		
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1	Registra		M	AR 03 199	yau al	Wander, .									



State of Maryland / Department of Health and Mental Hygiene 08002 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Deta of Deeth 3. Time of Death **Physician** Month Yaar NINA MARCH 1997 3:06 A.M. /Medicai 4e. Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BURNIE ARUNDEL HOSPITAL 7. Aga (In yrs. last birthday)
Yrs.

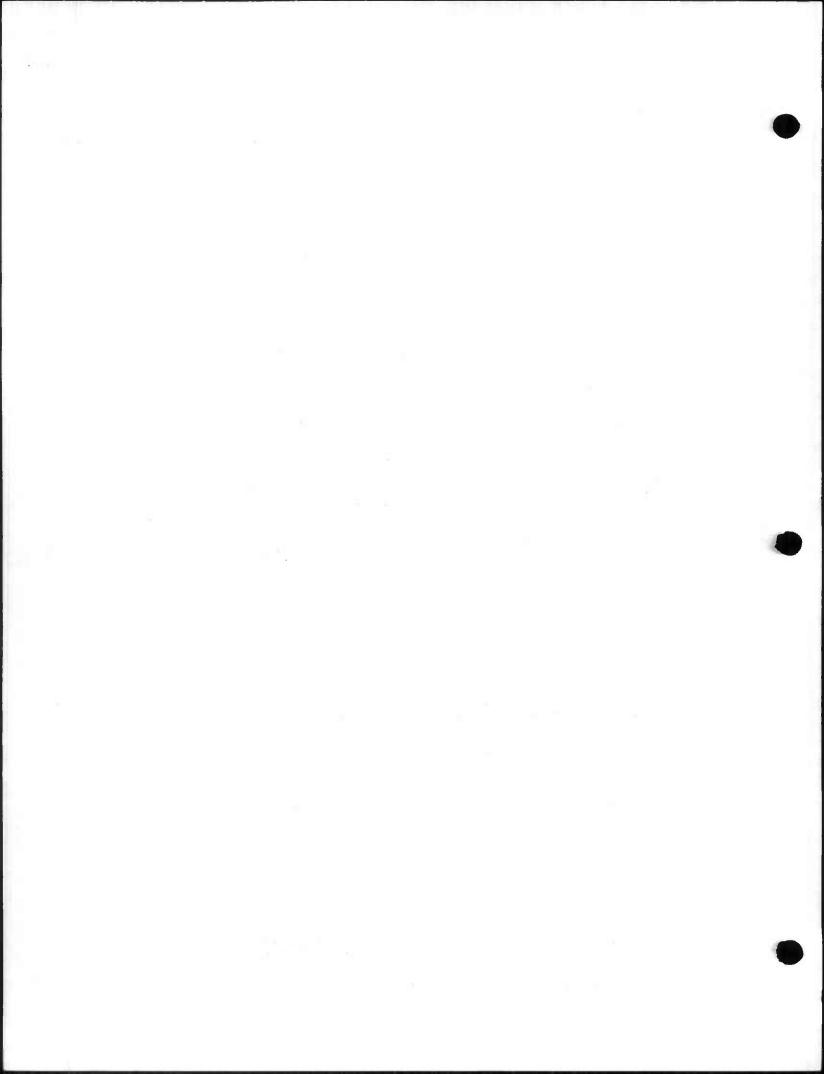
| H Undar 1 Yaar | H Undar 24 Hrs. | 8. Deta of Birth (Month, Day, Year) | 05-15-1916 GIEN ANNE ARUNDEL 5. Social Security Numbar 6. Sax 9. Birthplaca (Stete or Foraign **Funeral** 1 □ M 2 F Director 213-01-5126 MARYLAND Usual Rasidance of Dacedant the Maryland 10e. Stata 10c. City, Town or Location 10b. County show 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 23s-1 show traumatic event, the Medical Examiner must be notified at 1 ☐ Yas 2 No Director ANNE ARUNDEL CO. GLEN BURNIE 10e. Street and Number 10f. Zlp Coda 10g. Citizan of What Country? 200 FIFTH AVE S.E. 21061 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2\times No Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Navar Marriad 2 🕅 Married Baltimore, Maryland 21215-0020 1 ☐ Yes ② No Specity: þ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Hyglene. Elemantary/Secondary (0-12) Coitege (1-4or 5+) permit. Pages 1 and 2 should be filled w. Department of Health and Mental Hygien important: if them 27 is marriard other the KEY PUNCH OPERATOR WESTINGHOUSE 9 YRS 17. Fathar's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Sumama) Be 2 ALEXANDER MARKOFF BEULAH 19e. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Addrass (Street end Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) JANICE M. HEYING 402 DARLENE AVE. DAUGHTER LINTHICUM, MD. 21090 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, crematory or other placa) 20c. Location - City or Town, Steta 1 ☑ Buriel 2 ☐ Cramation 3 ☐ Removel from State MEADOWRIDGE MEMORIAL PK. 3-6-97 4 ☐ Donation 5 ☐ Othar (Spacify) ELKRIDGE, MARYLAND 22. Nama and Addrass of Facility SINGLETON FUNERAL HOME 21. Signature of Prineral St 1 SECOND AVE. S.W. GLEN BURNIE, MD. 21061 or complications that caused tha death. Do not antar the mode of dying, such es cardiac or respiretory errest, ist only one ceuse on each line. Approximeta **Physician** /Medical Immadiate Cause (F disaase or condition resulting in death) Examiner Completed by Physician/Medical Examiner physician and s the burial-tran Sequantially list conditions, if eny, laading to immediata causa. Entar Undarlying Causa (Disaasa or injury Box 68760. or Attending Physician: The lew requires that the death certificate be thet initiated events rasulting in daath) Last Dua to (or as a consaquanca of): attending p for usa es P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown signed t Records, 24b. Wara autopsy findings evellable prior to completion of causa of daath? 24a. Was en autopsy performed? 1 Tes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes casa refarred to medical axaminar? Be 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Assidence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOOA 1 Yas 2 No P this To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Mennar of Death 28d. Dascribe how injury occurred 28b. Tima of 5 Panding invastigation 1 Yas 2 No 2 Accidant 6 Could not be detarmined 3 Sulcida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Plece of Injury - At homa, farm, streat, factory, offica bullding, atc. (Specify) 4 Homicida 15 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, date end place, and due to tha causa(s) end mennar as stated.
2 Medical Examiner: On tha basis of axaminetion and/or investigation, in my opinion, daath occurred at tha tima, dete and place, end dua to tha cause(s) end manner stated. 29a. Cartifiar Medical (Check only one) 29b. Signature and title of certifiar 29c. License number 29d. Date signed (Month, Dey, Year) 7)30568 30. Name and eddrass of person who complated cause of death (Item 23a) (Type, Print) 7845 OAKWOOD RD. SUITE 204 REDDY M
32. Registrar's Signatura DAKWOOD PROFE SSIGNAL BUILDING 31. Dete filed (Month, Day, Year) State Registrar



State of Maryland / Department of Health and Mental Hygiene

				State of IV		Certifica		Death	•	Reg. No.	97	08003
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	/Medi				arris				03 Month	02 1	997	11:02p.m
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	Funeral Director		5. Sociel Security Number 6. S 216-40-4685 Ususi Residence of Decedent	Sex 7. A	ge (In yrs. lest bin	Yrs. If Unc	s Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birt (Month, Da) 1 – 27 –	h y, <i>Year)</i> 1943	9. Birthpi Coun Mar	lece (Stete or Foreign try) yland
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ore	- 五番号		20a. Method of Disposition		20b. Plece of	Disposition (A	leme of		Dste	20c. Location -		
LĚ	Page ment of mrt: If ary or		POBurial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specification)			el Ce			/6/97	Cambri	dae,	Md.
Baltimore,	permit. Departri Imports any inja	Î	21. Signature of Seneral Service Licer	DA'A	0	22. Neme	end Addre	ess of Fecility Bendain St.	nnie Si	mith F	uner	al Home
			23a Part Enter the disease, or com	plications that cause	d the deeth. Do r							Approximete Intervel Between
	Physician /Medical Examiner	ner	Immediete Cause (Finel disease or condition resulting in deeth)	e. Refa	Due to (or ss s	Adens	cure,	inona, l	Origin	un Prin	nery	Onset end Deeth
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/ita	striffic ctor,	Be	25. Wes case referred to medical examiner?					26. Plece of Deat	h (Check only o	ne)		
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Division o	ending Pt bath. or: After th		27. Menner of Death 1 Neturel 5 Pending investigation		y Year) 28b. T	ime of njury M	28c. Injur Wor 1 🗌	yet k? Yes 2 □ No	28d. Describe h	low Injury occur	red	
Divis	To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	286. Piece of in	ury - At home, fer c. (Specify)	m, street, fecto	ory, office		28f. Location (S City or Tow	Street end Numb n, Stete)	er or Rura	Route Number,
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			30. Neme and address of person who	M.D. /	leeth (Item 23a) (45-E. C	Type, Print)	St	SALISBUI	rer, Mos.	21861		
	Sta Registr	100	31. Dete filed (Month, Dey, Year) MAR - 7 19	32. Repistr	er's Signeture	Mandall	,	SAUSBU	/			

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	Funeral Director		5. Social Security Number 220-12-2076		Sax DD(M 2□ F	7. Aga (In yrs. 86	last birthday) Yrs.	If Undar 1 Yaar Months Days		8. Data of Bi (Month, De Mar . 28	th ay, Year) , 1910	9. Birthp Cour Ma	olaca (Stata or Foraign ntry) ry land
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	death with thems 23a or 2 cmust be no	Funeral Director	10e. Street and Number 204 Sp	ring	Road			10f. Zip Coda	21651		10g. Citizan of USA		ntry?
Maryland 21215-0020	urs after at, or its Examina	by	11. Marital Status 1 ☐ Navar Marriad 2[3 ☑ Widowed 4 ☐ Did		12. Was Dece Armed For 1 ☐ Yas If Yas, Giv Yaar or Da	rcas? 2 ☑ No a		Was Dacedant of I f Yas, specify Cub I ☐ Yas 2☑ No	Hispanic Origin? (Sp an, Maxican, Puaric Specify:	pecify Yas or No Rican, atc.)		ce - Amaric ack, Whita, fy: Blac	atc.
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o,	ificate be executed g physician and as the bunal-transit	Examiner	Sequantially list conditions if any, laading to immediate causa. Enter Underlying Causa (Disaasa or Injury		b	Dua to (d	or as a consaq	uance of):					
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n o			27. Manner of Death	anding	28a. Data o	f Injury h, Day Year)	28b. Tima of Injury	28c. Inju Wo			how Injury occu		
Sio	Attending or death. ector: Atter by the fune	atic	2 ☐ Accidant i	rvastigatio	n		.,,		Yas 2□No				
Division	s after death	Certification:		Could not b latarmined	28a. Placa	of Injury - At hig, atc. (Spacif	oma, farm, stra y)	aat, factory, offica		28f. Location (City or To		ber or Rura	al Routa Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Cartifiar 1 Ce (Check only one) 2 Ma	rtifylng Ph dical Exar	ysician: To tha l ninar: On tha ba and mann	sis of axamina	wladga, daath tion and/or Inv	occurrad at tha ti astigation, in my o	ma, data and placa, opinion, daath occur	and dua to tha red at tha tima,	causa(s) and m data and place,	annar as s , and dua to	tated. tha causa(s)
	To the within 2 To the comple	Me	29b. Signatura and title of o	ertifiar	-			29c. Licans	sa number		29d. Data signi	ad (Month,	Day, Year)
) cut	Du	un-	-		DO	0354		314	1197	
			30. Name and address of p	erson who	Completed cause	of death (Itan	n 23a) (Type, I	Print) 100	Brown	54. (heste	erto	wn md.
	Sta Registr	-	31. Data filed (Month, Day,			gistrar's Signa	ltura	1.00					
			MAR	- 6 19	197	- MARCHERY C	work-plane	MCDC.					



State of Maryland / Department of Health and Mental Hygiene

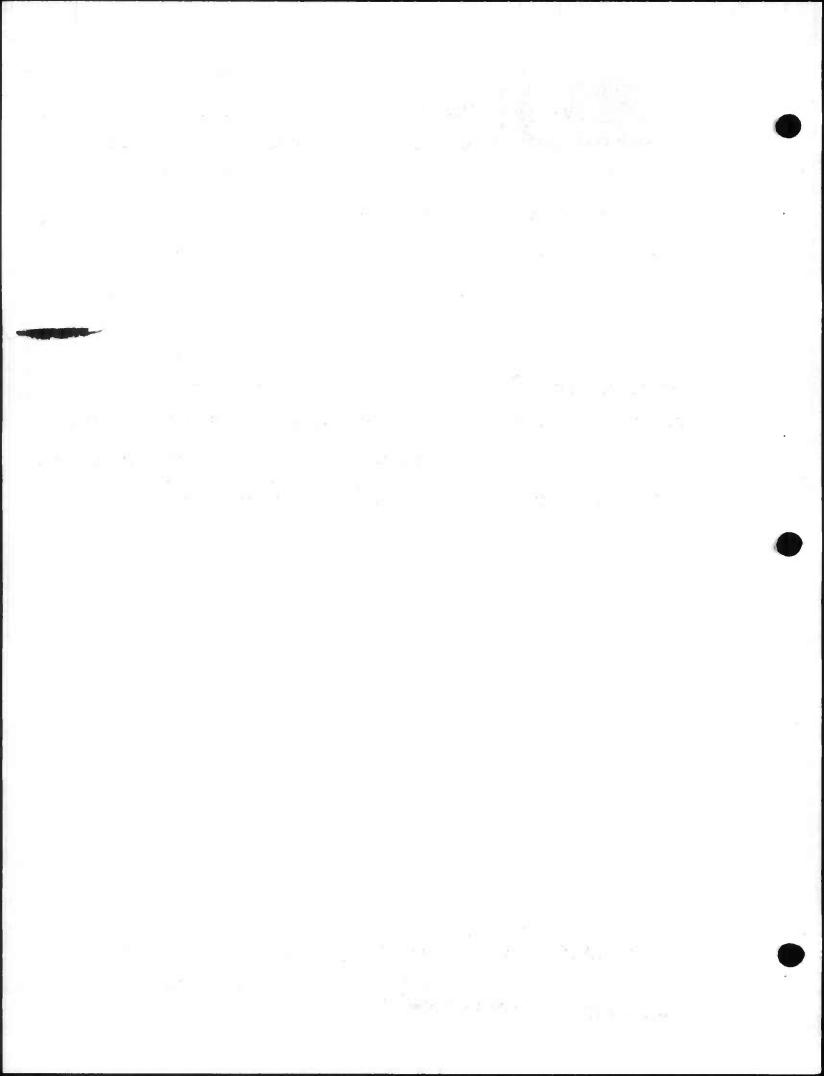
_			4 Occaded Nove (Tax Mid V. Laux			rtificate of		1	g. No.	7 0	8005
	Physic /Medi	cai	1. Decedent's Nema (First, Middle, Last) Blanche	Α	Н	ylander		2. Dete of Death Month March	Dey 4 19	97 9	:35a.m
	Exami Funeral	ner	4e. Fecility Neme (If not institution, give st Memorial Hospi 5. Sociel Security Number 6. Sax	tal 7. Age (fi	n yrs. lest birthdey)	If Undar 1 Year Months Deys	4b. City, Town, or Easton If Under 24 Hrs Hours Min.	B Date of Birth	Talbo	ot O Biotoples	a (Stete or Foreign
	Director		Usuel Residence of Decedent	M 2XF 8			TIOUIS IVIIII	Jan 12	,1915	lilföi	d, DE
	with the Marylan a or 28s-f show Lbs notified at	ito	10a. State 10b. County Iaryland Talbot		c. City, Town or Lo Easton	cation					Inside City Limits 1 X Yas 2 ☐ No
	23e or 28 sast be not	Il Directo	10a. Street end Number 52 Davis Lane			10f. Zip Code 2160	1	10	Og. Citizen of W	/het Country?	
020	hours after death tural", or items 2 at Examiner mu	by Funeral		. Was Decedant Eve Armed Forces? 1 ☐ Yes 2 🕱 No If Yes, Give Yaer or Detas:			dispenic Origin? (S an, Mexican, Puer	pecify Yes or No- o Rican, etc.)		A - American I k, Whita, atc.	
Maryland 21215-0020	d within 72 ho pions. r than "naturn the Medical I	Completed	15. Decedent's Educe (Specify only highest grede of Elementery/Secondary (0-12)	tion completed) College (1-4or 5+)		dent's Usuel Occup kind of work dona DO NOT use retire	pation during most of wo d)	rking	Owns	siness/indust	,
pue	that Hyg ad other event,	Be	17. Father's Neme (First, Middle, Last)		110	111011101101	18. Mother's Ne	ma (First, Middle, M			
aryli	should nd Mar marks umatic	70	Clarence H 19a. Informent's Neme/Reletionship (Type	udson	19b. Meillr	ng Address (Street	Blan	ICNE urel Route Number,	City or Town.	State. Zip Coo	de)
	ges 1 and 2 t of Health a If item 27 is or other tra		Donald D. Casso 20e. Method of Disposition 1 Disposition 3 Ref	2	401 20b. Plece of Dispo	Brookle sition (Name of netory or other ple	etts Ave	Dete 2	on, Mi		
Baltimore,	emit. Pa epartmen nportant: ny injury fice.		4 Donetion 5 □Other (Specify) 21. Signetura of Funeral Service Licensee			. Name end Addre	ess of Fecility	3/7 pein & N	Oxfor		
	Physician		23e. Pert1. Enter the disease, or complice shock, or heart failure. List only one		deeth. Do not ente	0 S. Ha	arrison ng, such as cardiae	St., Ea	ston,	MD 2	1601 proximeta ervel Between sat end Deeth
	/Medical Examiner	ner	Immediate Cause (Finel disaesa or condition resulting In death) e	Chron	to (or es e conseq	uence of):	pulm	anen	disco	ry.	eurs
x 68760,	The law requires that the death certificate be assecuted sta has been signed by the attending physician and page 2 should be detached for use as the bunal-transit	/Medical Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest		to (or es e consequento (or es e consequento)						
. Box	death of for u	Physician/M	Pert II. Other significant conditions contri	buting to death but no	ot resulting in the un	nderlying cause giv	ven in Pert I.	23b. Did tob	ecco usa con	tribute to the	cause of death
S, F.O.	ires that the death cer signed by the attendir d be detached for use	by Phys	Deligation	645	itio en	tw.ts		1240			y 4 Unknow
Division of Vital Records,	e law requira has been sig je 2 should t	Completed I						24e. Wes an perform		aveilab	autopsy findings ble prior to stion of cause th?
E I	ilclan: The certificata t rector, page		OF Was some referred to we discul					1□ Yes	3 2 No	1 □ Ye	s 2 No
	Physicia this certi ral directo	To Be	25. Wes case referred to medical exeminer? 1 Yes 2 No	pital: Inpatient	2 ER/Outpatieni	3□ DOA Oth	-00	th (Check only one oma 5 ☐ Resider		r (Specify)	
sion o	To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	1 ☑ Neturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Dete of Injury (Month, Day Yea	28b. Time of Injury	28c. Injur Wor M 1 🗆		28d. Describe how			
2	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer		4 ☐ Homicide determined	28e. Piece of Injury building, etc. (S)	pecify)			28f. Location (Str. City or Town,	Stete)		
	the Hos thin 24 ho the Fund mpletaly	Medical	29e. Certifier (Check only and) 20 Medical Examiner 29b. Signature and tille of certifier	an: To the best of my: On the basis of exa- end manner steted.	knowledge, deeth minetion end/or Inv	estigetion, In my o	pinion, deeth occu	rred et the time, de	te and pleca, a	nd due to the	ceuse(s)
	¥ ¥ 5 8		Dal Ille	cmin	7.18	29c. Licens	3749	29	d. Dete signed	(Month, Dey,	7 0 87)
			30. Name and address of person who comp Dr. D. Gregg Oli				s Lane,	Easton	, MD 2	21601	
	Sta Registr		31. Data filed (Month, Dey, Year)	32. Registrar's S	Signeture	2. 1.00					

State of Maryland / Department of Health and Mental Hygiene

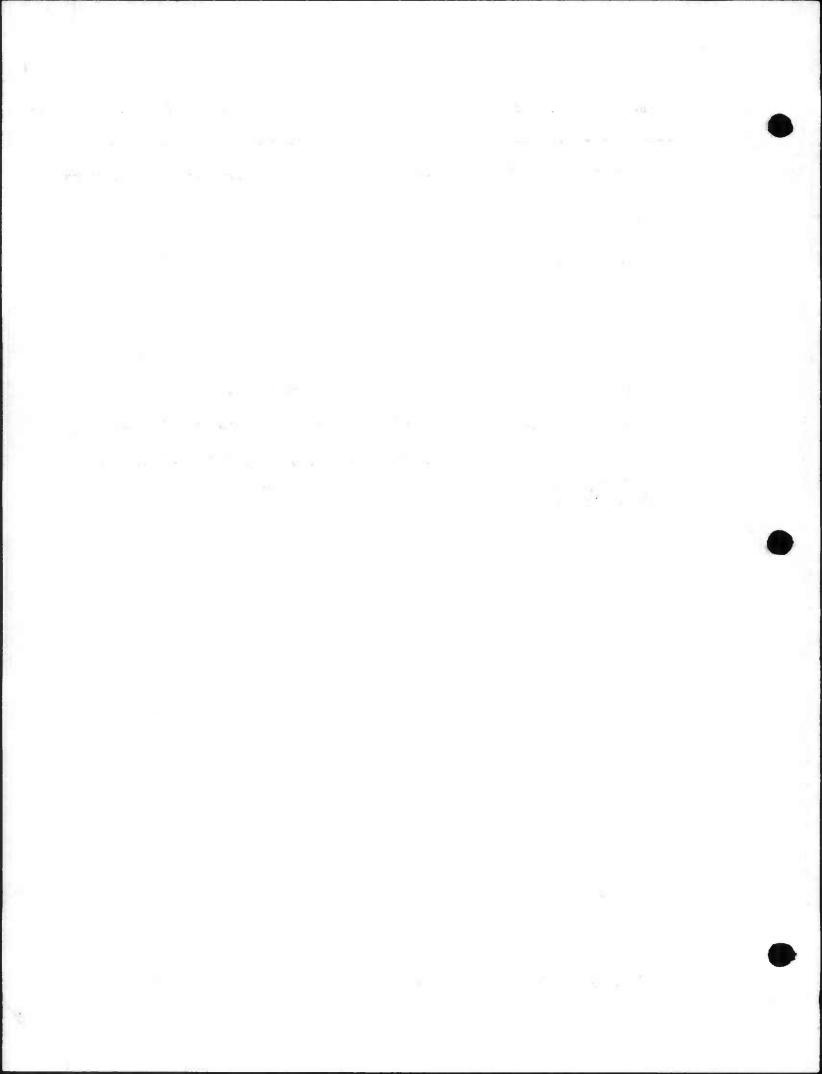
08006 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** March 1997 14 0106A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year 5. Sociel Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Day, DEC. 8, Birthplace (State or Foreign Country)
 MARY LAND 7. Age (In yrs. last birthday) **Funeral** Deys Months Hours 1 M 2 □ F 202 07 2226 80 Director Usual Residence of Decedent the Maryland r 28a-f show Lnotlified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND MONTGOMERY GAITHERSBURG 1 Yes 2 10 Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mast be n with t 23835 WOODFIELD ROAD 20882 UNITED STATES Pages 1 and 2 should be litted within 72 hours after death near of thesib and Metals Hygieshie.

The marked other then 'relural', or thems 23 ury or other traural', and thems 23 ury or other traumatic event, the Medical Examinent must Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Marital Status Bleck, White, etc. 1 Deyes 2 No If Yes, Give WWII Year or Dates: 1 Never Married 2 Merried Maryland 21215-0020 1 Yes 2 No WHITE þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN TIRE COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Р. NORMAN HINES MARY FINNEYFROCK 2 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23835 WOODFIELD ROAD, GAITHERSBURG, MD. 20882 BARBARA M. HINES, WIFE Baltimore, 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Important: If it any injury or o 1 Burlal 2 Cremation 3 Removal from State WESLEY GROVE CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 3/17/97 WOODFIELD, MARYLAND 21. Signature of Funeral Servica Licansee MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** tmmediate Cause (Final disease or condition resulting In death) /Medical Examiner Due to le as a consequença of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be axecuted usa as the bunal-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events and Due to (or as a consequence of) Box 68760, physician Due to (or es e consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? tha signed by 1 Yes 2 No 3 Probably 4 Schnknown þ g 24b. Were autopsy findings evellable prior to completion of cause of death? Completed 24e. Was an autopsy performed? has page 2 2DINO cartificata 1 Yes 1 Yes 22No funaral director, 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo Impatient Certification: To 2 ER/Outpatient 3 DOA After this 27. Menner of Death 28a. Date of Injury (Month, Day 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Investigation death. 1 Yes 2 No 2 Accident 24 hours after deat Funeral Director: 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide Hospital restifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner steted. Medical 29e. Certifier (Check only one) within 2 29b. Signature end titte of cary 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 54 31. Date filed (Month, Day, Year) State 8 1997 MAR 1 Registrar



				State of Ma		Department of I Certificate of		Mental Hy		97	08007	
	-		1. Decedent's Name (First, Middle, La.	st)			Douth	2. Date of De	Reg. No.		3. Time of Death	
я	Physici		Laura John	nson				Month 02	Day 2.3	Year 97	12:15 pm	
	/Medi Examir		4a. Facility Name (If not institution, give				4b. City, Town, or L				12.15 pm	-
1	LAUIIII		Caroline Nursing	Home			Denton		Carol	ina		
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. iest birt	thday) If Under 1 Year	If Under 24 Hrs.	8. Date of Big (Month, De			ace (State or Foreigny)	n
	Director	Р.	220-01-8749	□M 2\\ F	105	Yrs. Montha Days	Hours Min.		1	Mary		
	D .		Usuel Residence of Decedent					Julii 1	5,1072	11dly	Land	
	how		10a. State 10b. County		10c. City, Towr	or Location				10	d. inside City Limits	
	Se-f	cto	Maryland Carolin	e	Denton						1 X Yes 2 □ No	1
	ith th	Director	10e. Street and Number			10f, Zip Code			10g. Citizen of V	Vhat Count	ry?	
	23a		207 N. 4th Stree	et		21629			USA			
	eme er m	Funeral	11. Marital Status	12. Wes Decedent E Armed Forces?	ver in U,S.	13. Was Decedent of It If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No		e - America		
50	or it		1 Never Married 2 Married	1 ☐ Yes 2 N If Yes, Give	0	1□ Yes 2♥ No	Specify:	, , , , , , , ,		· Bla		
00	72 hours after death with the Maryland "natural", or items 23s or 28s-f show polical Exeminer must be notified at	d by	3⁄☐ Widowed 4 ☐ Divorced	Year or Detes:					Speciny	DIA		
5	in 72 ho "natur	Completed	15. Decedent'a Ed (Specify only highest gra		18a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of work	king	16b. Kind of Bu	isiness/Ind	uatry	
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0	Hygi Hasi		3rd 17. Father's Neme (First, Middle, Last)		п	ousewife	16. Mother's Nam	a (First Middle	Housewi			-
an	S a b	o Be							, wardon coman	0)		
Maryland 21215-0020	should and Men merka	2	Unknown 19a. informant's Name/Relationahip (7)	Tyne Print)	19h	Mailing Address (Street	Amanda		er City or Town	State Zin	Code	_
ž	and 2 ealth a n 27 is ser tras		Mildred V. Johns							,	0000)	
e,	一工事長		20a. Method of Disposition	5011	20b. Place of	605 Frankli Disposition (Name of		Date	20c. Location -		vn. State	
10	802 5		1 Buriel 2 Cremation 3 C		1	y, cremetory or other pla		/1/07				
Baltimore,	permit. Pa Departmen important: any injury ance.		4 Donation 5 Other (Specify 21 Signature of Funeral Service Licen		Sprii	ng Grove Cen	4	/1/97	Denton,	Md.		_
Ba	Dep mp any any		10/516	•			Smith Fun	eral Ho	me			
		Н	John A. Cr	ince			Maryland					
J.			Enter the disease, or composite or heart failure. List only	one cause on each iln	the death. Do n e.	ot enter the mode of dyl	ng, such as cardlac	or respiratory a	rrest,		Approximate interval Between Onset and Death	
0	Physician /Medical		Immediate Cause (Final	~ 0.	00.01	1.	1 1				10000	
п	Examiner		disease or condition resulting in death)			demen	tia				gears	
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	d ansit	Examiner		b	Due to for an a	onaequenca of):						
o,	axec in an	Еха	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		oue to (oi as a c	onaequerica or).				1		
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	g phy as th	w	resulting in death) Last		700 to (01 63 6 C	orisequence ory.				i		
Box	death certif e attending ed for use a	Physician/M		d								
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	s tha	by F	hypertensio	n, re	ual \$	ailure,			20110			
Records,	v requires that the de been signed by the should be detached	8	C-1	1				24e. Wes	an autopsy	24b. We	re autopsy findinga ilable prior to	
000	law re as bev	Completed	coronary a	rtery di	sease	•		pent	ormed?	con	apletion of cause	
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0	ding Phys h. After this funeral di		27. Manner of Death	28a. Date of injury (Month, Day	/ 26b. T	ime of 28c. Injury			how injury occurr	_		-
Ö	uttendin death. ctor: Aft y the fur	atic	1 Metural 5 ☐ Pending investigation		100.7		Yea 2 □ No					
Division	after death. Director: After	Certification:	3 Suicide 6 Could not be determined	28e. Placa of Inju- building, etc.	ry - At home, far	m, street, factory, offica		28f. Location (Street and Number	er or Rural	Route Number,	
<u></u>	rs after al Direction by	Ce		building, old.	(орвону)			ony or . o	m, clarcy			
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	29a. Certifier 15 Certifying Phy	vsician: To the best of	my knowledge,	deeth occurred at the tir	ne, date end placa,	and due to the	cause(a) and ma	nner as sta	ited.	
	the H tin 24 the F	8	one)	and manner stat	ed.	voi investigation, army c	pinion, death occur	red et trie time,	date and place, a	ING QUE TO	trie cause(s)	
	To the within To the comple	Σ	29b. Signature end title of certifier	=> MI		29c. Licens	e number		29d. Date signed	(Month, E	Pay, Year)	
				> WM		104	7534		212	4/9	7	
			30. Name and address of person who o					.10	- 1/-0			
			Wakik Zaki	920	Mark	eet St.	Denton	MD	21629			
	Sta		31. Date filed (Month, Day, Year)	32. Registre	's Signature	-Randall						
	Registr	ar	MAR - 4	1997	Davidson	-Randell						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician** Month /Medical 4b. City, Town, or Location of Deeth 4c. County of RENA FRANCES KELLEY 0857am 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner CHESTERTOWN KE
If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year)
November 13, KENT QUEEN ANNES HOSPITAL

5. Social Security Number 6. Sex 7. Age (In vrs. las If Under 1 Year . Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Days 216-48-5772 Yrs Director 89 1907 Maryland Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Funeral Director 1 Yes XX No Maryland Queen Annes Chestertown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23s or 126 Darden Road 21620 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 220No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. the Medical Examiner 1 Never Married 2 Married 8 altimore, Maryland 21215-0020 1 Yes 2 No Specify: by White Specify: 3 Widowed 4 □ Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry flad within 72 Hygiene. other then Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic/Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Pages 1 and 2 should be Mental marked Morris Wilson Ida V. Downey 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Department of Health a Important: if Item 27 is any Injury or other tra 90056. Richard Wilson Kelley/Son 126 Darden Road, Chestertown, Maryland 21620 20e. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from Stete 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donetion 5 ☐ Other (Specify) Wesley Chapel/March 3, 1997 Rock Hall, Maryland 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approxime Approximete Interval Between Physician Prece monia - type uncertain /Medical Immediate Ceuse (Final disease or condition resulting In death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown Diabitis Type II, Electrily te by 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was en eutopsy performed? Just alance. 2 10 NO certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) 2 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Netural 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours efter death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end menner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical (Check only 5 29b. Signature end title of contifier 29c. License number 29d. Date signed (Month, Day, Year)

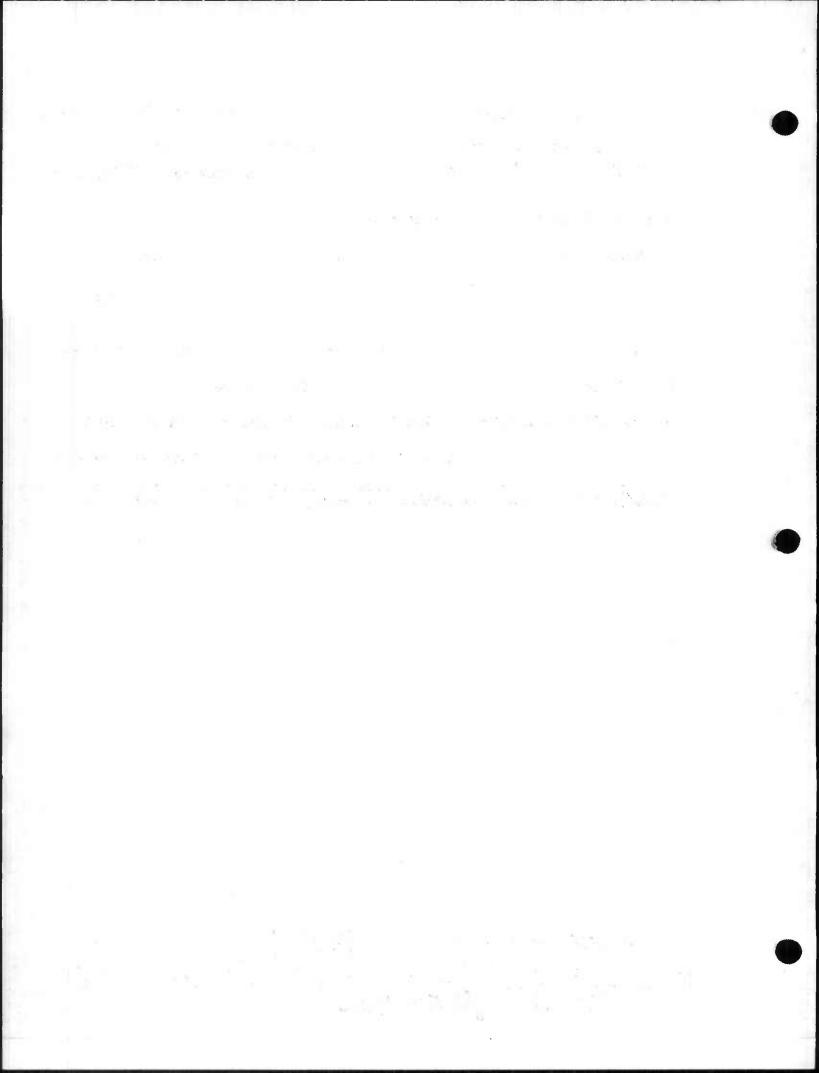
of death (item 23a) (Type, Print)

32. Registra's Rignance

21020-

C.G. Baumann, M.D.

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, Min	ddle, Last)			Cer	tificate of	Dealli	2. Date of D			3. Tima of Death
Physic		Ellen	Ger	evieve	K	elley			Month Februar	Day	Year 1997	10:30PM
/Medi Exami		4a. Facility Name (If not institu					19	4b. City, Town, or			ty of Death	10.30FM
EAGIIII	1101	739 Warren						Annapo	lic		nne Ar	undo1
Funeral	г	5. Social Security Number	6. Sex		ge (In yrs. I	ast birthdey)	If Under 1 Yaar	if Under 24 Hrs.	8. Date of B		_	
Director		213-50-8346 Usual Residence of Decedent	101	V1 2[X] F	76	Yrs.	Months Days	Hours Min.	Jan 3	1921		laca (State or Foral try) achusetts
death with the Maryland fre 23e or 28e-f show c.must.be.notified at	-	10a. State 10b. Cour		1		, Town or Loc					10	Od. Inside City Limit
S PH	Director		e Aru	ndel		Annapo						XX Yes 2□N
1 8 g	D.	10e. Street and Number					10f. Zip Code			10g. Citizen o	f What Coun	try?
0 th 230	rai	739 Warren					2140			United	State	S
hours after death with the Marylar lurel, or items 23e or 28e-f show at Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ M 3 □ Widowad 4 □ Divorce	arried	2. Was Deceden Armed Forces 1 ☐ Yes 2 ☑ It Yes, Give Year or Dates	? No	lt.	fas Dacedant of I Yes, specify Cub □ Yes 2☑ No	dispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)		ace - America ack, White, of the White	etc.
hin 72 ho a. "natur Medical J	Completed	15. Deced (Specify only high Elementary/Secondary (0-12		tion com <i>pleted)</i> College (1-4or	5+)	16a. Decede (Give k life. De	ent's Usual Occup ind of work dona O NOT use retire	pation during most of word d)	king	16b. Kind of		
d and and and and and and and and and an	Com	Elonional y Cooling (o 12	<u></u>	6	J+)	Tead	cher			1	Educat	ion
tal Hy d othe event	Be	17. Father's Name (First, Middle						18. Mothar's Nar	ne (First, Middle	a, Maiden Sume	ema)	
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S and a series		19a. Intormant's Name/Relation	nship (Type	, Print)		19b. Mailing	Address (Street	end Number or Ru	ral Route Numb	ber, City or Tow	n, Stete, Zip	Code)
and 88llh 827 8 tr		John F. Kelley	(Hus	band)		739 V	Varren D	rive An	napolis	, Maryla	and 21	403
or oth		20a. Method of Disposition 15 Buriai 2 Crematio 4 Donation 5 Other	n 3 □Ren	novai from State	Ce	metery, cremi	ition (Neme of atory or other ple		Data	20c. Location	- City or To	wn, State
nit. Pa satman ortant injury				1 1	St.		Cemete			Fairfax	c, Vir	ginia
Depa Impo any I	4	the led	Licensee	for		14	Name and Addre	f Glouce:	nn M. Ta	aylor Fu	uneral	Home, In
		23a. Part1. Enter the disease, shock, or heart failure. L	or complicit	ions that ceuse	d tha death							Approximata Interval Between
Physician /Medical Examiner)r	Immediate Cause (Final disease or condition resulting in death)	a	Sig	mos	A Ca	olon	Conce				Onset and Death
and il-trensit	edicai Examiner	Saquantially list conditions, if any, leading to Immediate	6 b		Dua to (or	as a consequ	ence ot):					
tificate be executed g physician and es the buriel-transit	dicai E	Saquantially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	C		Dua to (or	as a conseque	ence ot):					
n certific anding p	-		d									
death ce e attendii ed for use	icia	Part II. Other significant condi	tions contrib	huting to death I	hut not resul	ting in the unc	tarbing cause ab	en in Part I	23h Did	tobacco use c	ontribute to	the cause of death
that the ed by th detache	y Physician/N		TOTAL COTTO	butting to death i	Jul Hol 1630	ang in the thic	anying couse giv	on in Fait i,		Yee 28 No		ably 4 Unkno
aw requir as been s 2 should	Completed by								24a. Was	s an autopsy ormed?	ava	re autopsy tindings ilable prior to apletion of cause leath?
0 - 0	Son								10	Yes 2 No	1 🗆	Yes 2 No
certificate rector, pag	Be (25. Was cese referred to medic examiner?	el					28. Place of Dea	th (Check only	one)		
Physician: rthis certific rral director,	To	1 ☐ Yes 2 ☐ No	Hos	pital: 1 🗆 Inpati	ient 2 🗆 E	R/Outpatient	3 DOA Oth	ar: 4 ☐ Nursing H	ome 5X Res	Idence 6 🗆 Of	her (Specify)
Attending Pt ir death. sctor: After th by the funera		- C / 100100111	ing tigation	28a. Date of Inj (Month, Da	ury By Year)	28b. Tima ot Injury	28c. Injur Wor M 1	yat k? Yes 2 □ No	28d. Describe	how injury occu	irred	
To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	Certification:	3 Suicide 6 Coul 4 Homicide dete	d not be mined	28e. Piace of In building, e	jury - At hor tc. (Spacify)	na, farm, stree	et, factory, office			(Streat end Num wn, Stete)	ber or Rural	Routa Number,
To the Hospital or / within 24 hours after To the Funeral Directorpletely filled in the	edicai	29a. Certifier (Check only one) 1 ℃ Certify 2 ☐ Medica	ing Physici I Examiner	an: To the best On the basis of and manner si	of examination	ledge, death on and/or inve	occurred at the tir stigation, in my o	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and m date and place	nanner as sta , and due to	ated. the cause(s)
ro th	Me	29b. Signature and title of certif	m) /	. 1			29c. Licens	a number		29d. Data sign	ed (Month, E	Day, Year)
0 4 <		Jutter 30. Name and address of berse	/ (Le	leted cause of	ey	2201 07 00	D23	060				, 1997
		Anthony J. Ca	labre	se, M.D	. 171	Defens	se Hwy A	nnapolis	Maryla	and 2140	01	
Sta Registr	10	31. Date tiled (Month, Day, Yea MAR 0		32. Regist	rar's Signatu	son-Pano	602					

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		1.3-1			Certifica	ate of L	Death		Reg. No.	97 0801
Physic	ian	Decedent's Nema (First, Middla, La						2. Data of Dec	eth Day	3. Time of Dea
/Medi	ical	Francis Howa 4e. Fecility Name (If not institution, giv	٠, -	r.		4	h City Town o	March r Location of Death	4 1997	9:45A
Exami	ner									
Funeral		1911 Napier Dr 5. Social Security Number 6. S		yrs. last birt	hday) If Und	ar 1 Year	Foresty if Undar 24 Hr	ville 's. 8. Data of Birt		ce George
Director		216-16-4290 Usual Rasidanca of Decedent	M 2□ F 71		rs. Month	s Days	Hours Min		v. Year)	9. Birthplaca (Stata or Fo Country) Maryland
and and		10a. Stata 10b. County	100	City, Town	or Location					10d. Insida City Li
the Marytar r 28a-f show notified at	Director	MD Prince			restvil	le.				1 Tas 2
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1020 ours after dea al', or flams Examiner m	by Funeral	11. Marital Status 1 Never Marriad 2 Married 3 Widowed 4 Divorced	12. Was Decedant Ever Armed Forcas? 1 ☑ Yas 2 ☐ No If Yas, Give Year or Datas: ₩₩			edant of His ecify Cubar 2⊠Xo	spenic Origin? (n, Maxican, Pua Specify:	Specify Yas or No- into Rican, atc.)	14. Rad Bla Specif	ce - American Indian, ck, Whita, etc.
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Baffmore, Maryland 21215-0020 semit. Pages 1 and 2 should be filled within 72 hours at oppartment of Health and Mental Hygene. Important if them 27 is marked other than "natural", or myortant if them 27 is marked other than "natural", or myortant if them 27 is marked other than "natural", or myortant if them 127 is marked other than male.	Comp	Elemantary/Secondary (0-12)	Collega (1-4or 5+)		Plumbe				Plu	mbing
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srylar should by od Menta marked marked	To	William Frankl				1		elma Howa		
Main and 2 st land 2 st la		19a. informant's Name/Ralationship (S Terry L. Kirby (S						Ru <i>ral Rou</i> ta <i>Numbe</i> e Alexand		, Stata, Zip Code) .rginia 22308
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Land Page 1		1√3Burlal 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Othar (Specify) L	akemo	nt Memo	rial	Gardens	3/7/97	Davidso	nville, Mary
Ball permit Depart Import any in		21. Signature of Funeral Service Group	and		22. Nama 8	and Addras	s of Facility Joh Glouce	nn M. Tay	lor Fun Annapo	eral Home, I
Physician /Medicai		23a. Part1. Enter the disease, or compensor, or heart failure. List only Immediate Causa (Final disease or condition						ac or raspiretory er		Approximete intervel Batweer Onsat and Death
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OT VITAL Physician: This certificater ald director, pa	2	1 Yas 2 No	Hospital: 1 ☐ inpatient.	ER/Out	oatient 3 D	OA Otha	4 Nursing	Home 5 Rasid	ance 6 Oth	ar (Specify)
VISION O Attending Ph or death. ector: After thi by the funeral		27. Mannar of Deeth 1 Natural 5 Panding 2 Accidant Invastigation	28a. Date of injury (Month, Day Year	28b. Ti	ma of ury M	28c. injury Work 1 ☐ Y	et ? as 2 □ No	28d. Describe h	ow Injury occur	red
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Los to the Hospital or within 24 hours after To the Funeral Director Completely filled in	edicai	29e. Certifiar (Check only one) 1 Certifying Phy 2 Medical Exam	rsician: To the best of my interest on the basis of axamend manner steted.	nowledga, Ination and	daath occurred or invastigetion	at tha time n, in my opi	e, dete and plac nion, daath occ	a, and due to the curred at tha tima, d	ausa(s) and me ate and plece,	ennar as stated. and due to the cause(s)
To the Mithin Fo the	Me	29b. Signeture end title of certifier	^		29	c. Licansa	number	2	9d. Dete signe	d (Month, Day, Year)
->-0		1 (grun A (Rullen		5	40	21.6		3/4	
		30. Nema and address of person who d		tam 23a) (T みレご	ype, Print)	404	W HE	TOHIS		
Sta	te	31. Data filed (Month Day Year)	7 32. Flogistrar's Gi	onature 9	Onda DO				,	

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	•		Certificate of Dea	ath	Reg. No.	97 08011
-	Physic	ian	1. Decedent's Neme <i>(First, Middle, Last)</i> Louis Franklin Kli	ne Sr. Fel		3. Tima of Death
d	/Medi	cal		ty, Town, or Location of De		
7	Exami	ner		reston		oline
-	Funeral		5. Sociel Security Number 6. Sex 7. Age (In vrs. lest birthdev) If Under 1 Year If Ur			
0	Director		215-14-4963 1XDM 2DF 73 Yrs. Months Deys Hou	ours Min. (Month, NOV.	Birth Day Year) 923	9. Birthplece (State or Foreign Country) MD.
	you m		Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary Hed	ţ	MD Caroline Prëston			1v Yes 2□No
	7 28 P	ie ie	10e. Street end Number 10f. Zip Code	7	10g. Citizen of	What Country?
	23 a d	aic	5980 Newton Road 216	555	U.S	SA
Maryland 21215-0020	ours after doath with the Marylar at, or thems 23s or 28s-f show Examinar must be notified at	by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Wes Decedent Ever in U,S. Armed Forces? 1 Lever Solve 1 Lever in U,S. Armed Forces? 1 Lever in U,S. Armed Forces? 1 Lever in U,S. Armed Forces? 1 Lever in U,S. If Yes, specify Cuban, Men of Yes, Solve Year or Detes: 1 Lever in U,S. If Yes, specify Cuban, Men of Yes, Solve Year or Detes:	ic Origin? (Specify Yes or exican, Puerto Rican, etc.) ec/fy:		ce - American Indian, ck, White, etc. y: White
50	72 ha	Completed	15. Decedent's Education 16a. Decedent's Usuel Occupation (Specify only highest grade completed) (Give kind of work done during in the complete of the complet	most of working	16b. Kind of B	usiness/Industry
21	e se se	ğ	Elementery/Secondery (0-12) College (1-4or 5+) life. DO NOT use retired)			
12	hard a		11 0 Carpet M			arpet
and	od of the state of	Be		Mother's Neme (First, Mide		ne)
2	thouk of Mo mark mark	J.	Louis F. Kline Sr. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Nu	eresa Pro	3	State Zin Code)
	nd 2 is at 27 is at 1 treu		Deborah Lindsay/Daughter 5980 Newton R			1D.21655
re,	s 1 and if Health Nam 27 other t		20e. Method of Disposition 20b. Place of Disposition (Name of	Dete	7	- City or Town, Stete
Ĕ	8 = 8		1 Buriel 2 Cremetlon 3 Removel from State Capital Crematory	y 2/24/97	Dover,	Del.
Baltimore,	permit. Pu Department Important any injury once.		21. Signature of Funerel Service Licensee 22. Name end Address of F-Williamsor	n Funeral	Home	
	_		23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such shock, or heart feilure. List only one cause on each line.	urg MD 21	632 v arrest.	Approximete fnterval Between
9	Physician /Medical Examiner		transdiete Ceuse (Fine) disease or condition MVCAPDIAE 7 ALFAR	COTION		Onset end Deeth
Box 68760,	eath certificete be executed attending physician and for use es the buriel-transit	Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in deeth) Lest e. Due to (or es a consequence of): Due to (or es a consequence of): Due to (or es a consequence of): C. Due to (or es e consequence of):	CULAR D	ISEASI	Chronic
0	the a	ysic	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in P	Part f. 23b. D	td tobacco uae co	ntributa to the cause of death?
0	es that the de	by Ph	DIABETES MELLITUS	1	☐ Yes 2☐ No	3 Probably 4 Unknown
Records,	aw requir	Completed b	LUNG CANCER		es an autopsy enformed?	24b. Were autopsy findings aveilable prior to completion of cause of death?
	The ate h	Son		11	□Yes 20 No	1 Yes 2 No
Vital	Physician: The this certificate ral director, pag	Be	examiner	Plece of Deeth (Check on	ly one)	
of	hysic this c al dire	2	7-3		esidenca 6 🗆 Oth	
	After funer	lon	27. Menner of Deeth 28e. Dete of Injury 28b. Time of 28c. Injury et Work?		e how Injury occur	red
Division	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Pleca of fnjury - At home, farm, street, fectory, office bullding, etc. (Specify)	28f. Location	n (Street end Numb Town, Stete)	ber or Rural Route Number,
	n 24 hour n Funera	edicai	29e. Certifier (Check only one) Certifying Phystclen: To the best of my knowledge, deeth occurred at the time, determiner: On the basis of examinetion end/or investigation, in my opinion, and menner steted.	te end plece, end due to to , deeth occurred et the tim	he ceuse(s) and ma ne, dete end place,	anner as stated. end due to the cause(s)
	To the within To the comple	M	29c. Signature and title of certifier MD M.F. 29c. License numb D1464	64	29d. Dete signe	d (Mgnth, Dey, Year)
			30 Name and states of person who completed cause of death (Item 23e) (Type, Print)	MDN	629	101
ľ	Sta		31. Dete filed (Month, Dey, Year) MAR - 5 1997	1112		

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the pregnal in box 1+2
as opposed to the photo copy,
used white out to try
and correct my mistake.

Lless Willow/Mh
3/24/97

Hospital or Attanding Physical Physical Physical Phous effer death, Funeral Director: After this state filled in the funeral Physical Phys	Dy ula	Certification:	XXNatural 5 ☐ Pending 2 ☐ Accidant invastigat 3 ☐ Suicida 6 ☐ Could not 4 ☐ Homlclda	on be 28e. Place	th, Day Year,	Injury	М	1 🗆	rk? Yas 2 □ No	28f. Locatio		nd Numb	per or Rural Rou	ite Number,
	8	9	axaminer? 1XIXas 2□ No 27. Menner of Death	Hospital: 1 28a. Deta		☐ ER/Outpatian		Oth	nar: 4□ Nursin	g Homa 5 ☐ R	asidanca		ar (Specify)	AT SCENE
F # 8	ior, paga	Be Com	25. Wes casa refarred to medical						26. Placa of	Death (Check or	Yea 2	□ No		2 □ No
requii	8	Completed by F								24a. V	/as an auto erformed?		24b. Wera au	utopsy findings a prior to ion of causa
tha c	lleched lo	hysici	Part II. Other significant conditions	contributing to d	eath but not i	asulting In tha u	ndarlying car	usa giv	van in Part I.		Old tobacco		ntribute to the	
leath certificata b attending physic	200	Physician/Med	Table 11 add 11 add 1	d										
ata be axecuted	a Da	Ca	Sequantially list conditions, if any, laading to immadiate causa. Enter Undarlying Cause (Disease or Injury that initiated events rasulting in daath) Last	C		o (or as a consec								
petr	Insir	Examiner		b		o (or as a consec	•					•		
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gas	olar)		1 ☐ Burial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spe-	cify)	State	ee Crem	matory or oth atory	ar pla		rch II, 1997	Cl	into	on	nata
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2 should be and Mentai Is marked o	Traumetic avent	ToB	Randleson 19a. Informent's Name/Relationship	Lyles		40h Maili	no Address (Ctroot		Minnie			ris	-1
filed withli Hygiena. other then	ant, Inc	Ве Сош	11th 17. Father's Neme (First, Middle, La	N/A	1-401 37)	Un	employ	ed	18. Mothar's	Nama (First, Mid		N/A Suman	na)	
within 72 ho ena. then "netur	Medical	Completed	15. Decedant's (Specify only highast of Elamantery/Secondary (0-12)	Education grada completed) Collega (1.40r 5 t)	16a. Dece (Give lifa.	dant's Usual kind of work DO NOT usa	Occup dona retire	pation during most of d)	working	16b. K	ind of B	usiness/Industry	1
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th with the	INT DO NOT	al Director	10e. Street end Number 5901 Woodland	Lane			10f. Zip 0	ode 1073	35			tizan of V	What Country?	
tha Marylandr 28a-f show	The Date	tor	10a. Stata 10b. County Maryland Prince	George'		City, Town or Lo								nside City Limi □ Yas 2ሺ1
Direc	tor		219-72-7204 Usual Rasidance of Dacedant	1MM 2□ F	40	Yrs.	Months	Days	Hours N	Jan.	Day, Year) 1,195	7	Floric	la
Fund			6100 ALLEN 5. Social Security Number 6	TOWN R		rs. last birthday)	If Undar 1	Yaar	If Undar 24	PRINGS	Pr Birth Day, Year)		9. Birthplace	
/N	ledic amin	al	4a. Facility Neme (If not institution,				TILE		4b. City, Town,	MARC or Location of D			997 4 of Death	:00 PI
Phy	ysicia	n	DAVID		COTT		LYLE			2. Data of Month	Death	y	Year	Tima of Death

State Registrar

30. Name end addrass of person who complated causa of daath (Itam 23a) (Type, Print) 31. Dete filed (Month, Day, Year)

29b. Signatura end title-of-cortifier

David

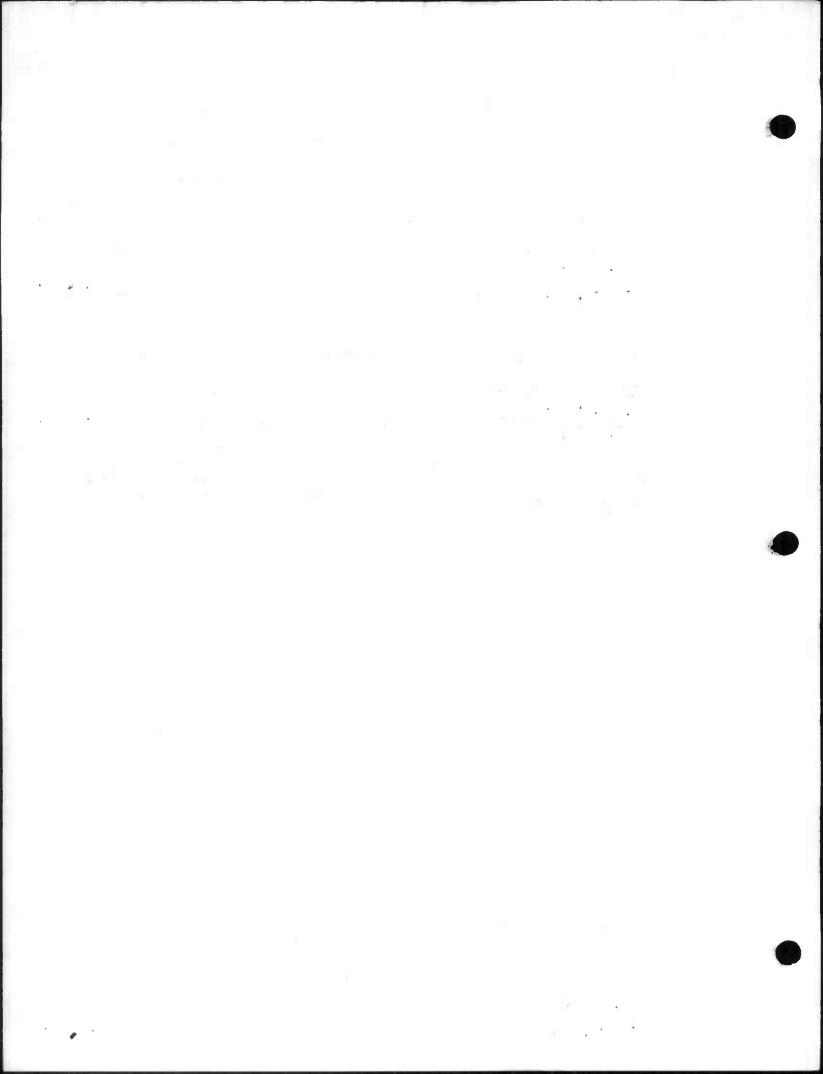
29c. Licansa number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Data signed (Month, Day, Year)

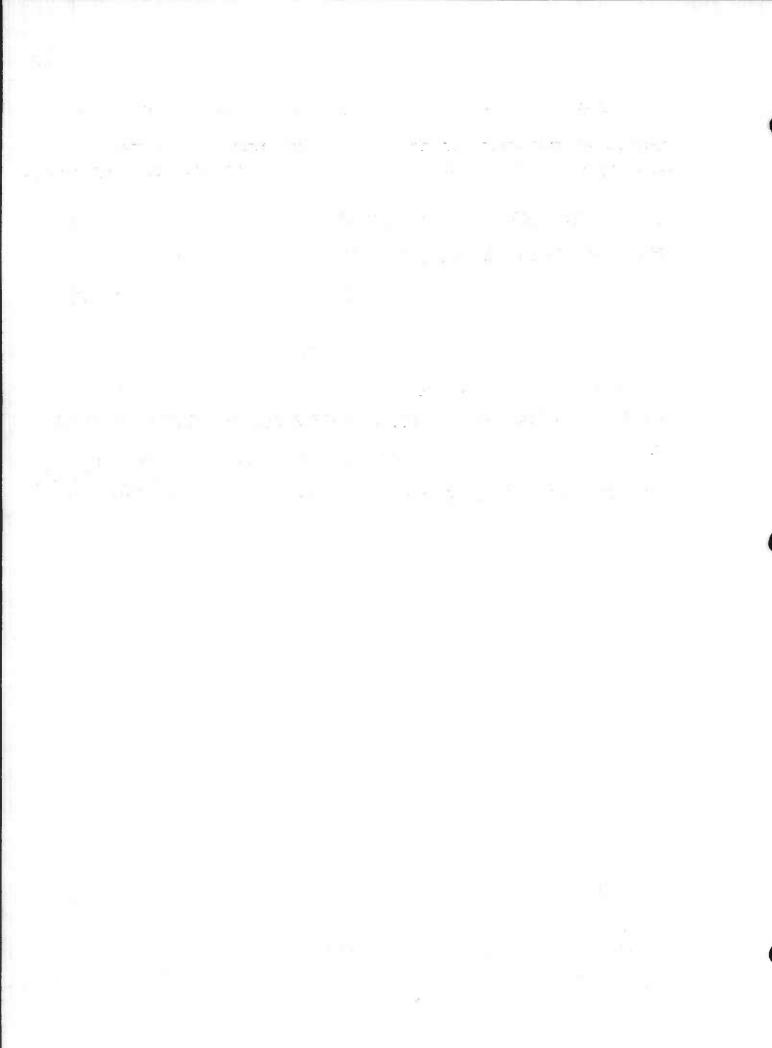
MARCH 11, 1997



State of Maryland / Department of Health and Mental Hygiene Q 7

97 08013

							Certificate	of Dear	h	Re	g. No.	,	00010
			1. Decedent's Neme	(First, Middla, L	ast)					2. Date of Deet Month		Voor	3. Time of Death
	Physic /Medi		CH <i>A</i>	RLOTTE	S		1	INTO	N	MARCH	Dey 199	Year 7	0545
	Exami		4e. Facility Name (#	not institution, g	ive street end numb	er)				cation of Deeth	4c. County	of Deeth	
			PENTINSIII	A REGIO	NAL MEDIC	AI. CENTE	D	C A	TTCDIII	οv	LITC	OMTOO	
	Funerai		5. Social Security Nu	umber 6.	Sax 7.	Age (In yrs. lest b	pirthdey) If Under 1	Yaer If Und	LISBUI Ser 24 Hrs. s Min.		Year)	9. Birthpl	ece (Steta or Foreign
ш	Director	н	176-26-1	.291	1□M X □F	61	Yrs.	Jeys Tiour	10111).	09-23-	1935	PENN	SYLVANIA
	p .		Usuel Residence of			10. 0% T							
	aryta show id at	및	10a. Stete	10b. County			wn or Location					10	d. Inside City Limits
	the M 28a-f notifie	cto	MD		MICO	P	ARSONSBU						1 Yes 2 No
	£ 6 8	급	10e. Street and Num				10f. Zip C	ode		11	Og. Citizan of V	What Count	ry?
	ath w	Funeral Director	7640 P	ARSONS	BURG RD	BOX 2		849			U.S.A		
	Berns Berns Der mx	une	11. Maritel Status		12. Was Decede Armed Force	95?	13. Wes Deceder If Yas, specify	t of Hispanic Cuben, Mexi	Origin? (Spe can, Puarto i	ecify Yes or No- Rican, etc.)		e - Amarica ck, White, e	
20	# 95	by F	1 Never Merrie 3 Widowed		1 ☐ Yas 2 If Yes, Give	K No	1□Yes 💥	No Spec	ify:		Specify	WH	ITF
8	요 불교			/\	Yaar or Data		s. Decedent's Heuri	Jeouration.			10h Kind of B	unin and find	
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ä	Dep firms any		> B.	Reits	t Phypn	a, OFS,	BOUN	DS FU	NERAL	HOME	SALISH		
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Vis	or Attendi	tific	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine	d 28a. Pieca of	Injury - At home, etc. (Specify)	ferm, street, fectory, o	ffice		28f. Location (St City or Town		er or Rura	Route Number,
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edicai	29a. Certifier (Check only one)	Certifying P	hysician: To the be miner: On the best and menner	s of exemination e	ge, death occurred et and/or investigetion, in	the time, dete my opinion, o	end plece, e leeth occurre	end due to the co	euse(s) end me ete end pieca,	enner as ste end due to	eted. the ceuse(s)
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	/		100	lat	an MC)	D4	2523	2		3/1/0	77	
	5		30. Name and eddre	ss of person who		of death (Item 23a		a	0	A -) 0.0		
	Sta	te	31. Dete filed (Month	h, Dey, Year)	Jala m	D 610	1-D Eas	lem 1	share	Wx, (.	Lalish	my, l	my 21801
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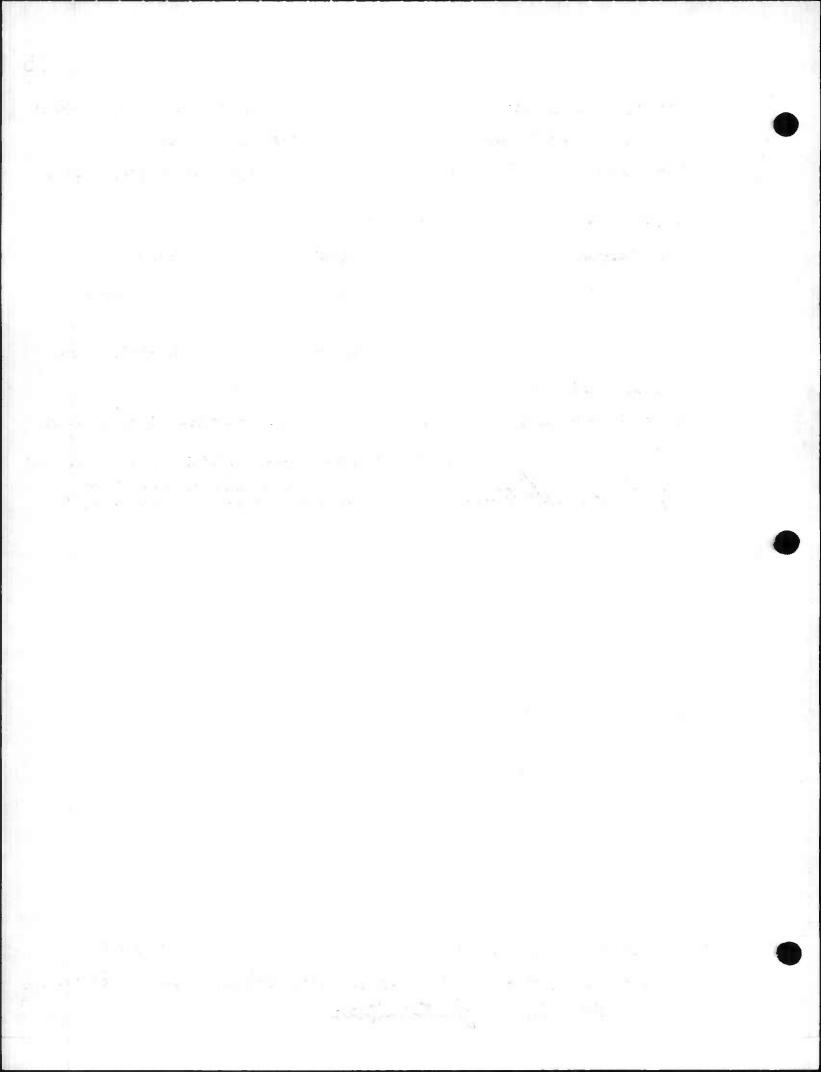
State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificat	e of	Death		F	ieg. No.	9/	081	0 14
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П	Physic		Robe	rr Lee	T. a	ndon					Month February	23. 19	97	8:15	D.M.
	/Medi Examii		4a. Facility Name (If not institution			indon			4b. City, To	wn, or Lo	ocation of Death		nty of Death	1	
7	Exami		Edw.W.McCready	Memorial	Hospit	al			Cri	sfie	eld .	Some	erset		
	Funeral		5. Social Security Number	6. Sex	7. Aga (In yrs.	last birthday)	If Under	1 Yaar Days	If Undar Hours	24 Hrs. Min.	8. Date of Birth	Voer	9. Births	olaca (State d	or Foraign
и	Director		218-03-8067	11 [®] M 2□ F	78	Yrs.	WOTHERS	Days	Hours	PYTHT1.	Dec. 19	,1918	Mar	yland	
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	aryta asho dat	F	,		TOG. CI	y, Town or Lo	sfiel	a					1	10d. Inside C	2 No
	M Page	Director	-	merset		CII					-	2.115			248140
	£ 5 8	吉	10e. Street and Number 3217 Boone Roa	ad			10f. Zip	218	217		1	0g. Citizen	of What Cour	ntry?	
	death with the Maryland or 23a or 28a-f show crust be notified at	Funeral			adent Ever in U	C 142	Was Dass			-1-0 (0-		14.5	USA	non faultan	
	Her de	ů.	11. Maritai Status 1 ☐ Never Married 2 ☐ Marri	Armed Ec	edent Ever in U proes? 2 NoWOL	,s. 13.	If Yes, spe	cify Cub	an, Mexicar	gin 7 (Sp n, Puarto	ecify Yes or No- Rican, etc.)		łace - Amario Black, Whita,		
20	hours atter arral", or its at Examins	by F	3 Widowed 4 □ Divorced	if Yes, Gi	ve War	II	1 🗆 Yas	2 X No	Specify:			Spe	city: Wh	ite	
Maryland 21215-0020	72 frours after death with the Marylar "natural", or literie 23a or 23a-f show idical Examinar must be notified at	P	15. Decedan	t's Education		16a. Dece	dent's Usua	al Occus	petion			16b. Kind of	f Business/In	dustry	
215	within 7. ene. than 'n the Medi	ple	(Specify only higher Elementery/Secondary (0-12)	st grade completed) College (I dor E.)	(Giva life.	kind of wo DO NOT u	rk done se retire	during mos d)	t of work	ing			,	
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/la		To	Charles J	• Landon					Не	nrie	tta Mar	shall			
ar	d 2 should in and Mar 7 is merica traumetic		19e. Informent's Neme/Relations	hip (Type, Print)							al Route Numbe		wn, State, Zip	Code)	
	在型 N L		Connie Landon	(daughter)					Road	- C	risfiel	d, MD	2181	7	
ore			20a. Method of Disposition 1 Disposition 2 Cremation	3 □Removal from		Plece of Disposematary, cra-	osition <i>(Nai</i> ma <i>tory or</i> c	ne of other pla	ce)		Date	20c. Locatio	on - City or To	own, Stata	
Ë	artment ortant: I injury o		4 ☐ Donetion 5 ☐ Other (S		Sa	alisbu	ry Cr	emat	cory	2/	28/97	Salis	sbury,	MD	
Baltimore,	permit. Page Department of important: If any injury or once.		21. Signature of funeral Servica	Licansee	1	2:			ss of Facilit		uneral	Home			
	20200		Robert H. H	Bradshaw	an						- Crisfi		ID 21	817	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that only one cause on e	aused the deet ach lina.	h. Do not en	ter the mod	le of dyl	ng, such as	cardiac	or respiratory arr	est,	1	Approximat Interval Bet	tween
Ŋ.	Physician		CONTROL DE LIBERTA		4		01	0	-0-6	,		\mathcal{D}	í	Onset and	Death
ď	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. a	reem	ma	of O	20	stale	w	eth b	Done	2	34	Prs
		20			Due to (d	as a Cooke	gylence of):		2.	Pa	ith I	/	1		
	peti nsit	Examiner		b. a				(me	Ka	exasi	1			
7	eath certificate be executed attending physician end for use as the bunal-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Due to (c	r as a consec	quence of):						1		
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	g phy as th	ledical	rasulting in death) Last		Dua to to	i as a consac	quarica oi).								
Box	h cert endin	an/M		d									-		
	0 0 0	Physician	Part II. Other significant condition	ons contributing to de	gath but not res	ulting in the u	indedying o	ause gh	ven in Part I	. 1	23b. Dld to	bacco use	contribute to	o the cause	of death?
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o	Physic this c	P	1 Yes 2 No			ER/Outpatier		JA			me 5 Resid			5/)	
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Sic	Attanding or death.	Icat	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could	not be	of Indiana At he	me team at	M		Yes 2	INO	28f. Location (S	troot and blu	mbarar Pur	al Pouta Alum	nhar
Division	三名書る	Certification:	4 ☐ Homicide determ		of Injury - At heng, etc. (Specif		reet, lactory	y, omca			City or Tow		mber or riura	II FIOURE PAUL	Wei,
	ours ours meral		29a, Certifier 187 Certifyin	g Physician: To the	best of my kno	wledge deat	h occurred	et the tir	me date en	d place	and due to the o	ause(s) end	menner as s	teted	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	(Check only 2 Medical one)	Examinar: On the bi	asis of examina nar stated.	tion and/or in	vestigation	, in my o	pinion, dee	th occur	red et the time, o	ate end plac	e, and due to	the cause(s	5)
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Me	29b. Signature and title of certifie	01	2		296	c. Licens	se number		2		ned (Month,		
			Lugar	o M. ()	Sel	land	-	D:	295	05		2 -	- 24	-97	7
			ati. Name and address of person	who completed caus	e of deeth (Iten	23e) (Type,							-24	218	201
-		2	GREGORIO	M. BE	Lb09	0, M	.D. 5	530	2 @H	INA	BERRY	DR.	SALIS	BUR;	Y MD
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	Registr	ar	MITH O D 1991 C	/											

State of Maryland / Department of Health and Mental Hygiene

08015 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0430 AM VIOLET GREENWOOD LEIBY 02 1997 MARCH /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner KENT & QUEEN ANNE'S HOSPITAL CHESTERTOWN KENT If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕮 F 213-44-2247 Yrs. Director September 17, 1915 Maryland Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Funeral Director Maryland Kent Chestertown 190 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? must be n 24295 Langford Road 21620 U.S.A. items: 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. filed within 72 hours after 1 Never Married 20 Married ò 21215-0020 White 1 ☐ Yes 2 No Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic/Own Home Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Pages 1 and 2 should be nent of Health and Mental William Edward Greenwood Olive Bowers and l 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health Important: If Item 27 Edward M. Leiby/Husband 24295 Langford Road, Chestertown, Maryland 21620 20b. Piece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 Burial 2 Cremation 3 Removal from State Injury 4 Donetion 5 Other (Specify) St. Pauls Cemetery/March 5, 1997 Chestertown, Maryland 21. Signature of uneral Service Licensee 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximate Intervai Betwe **Physician** /Medical Immediate Cause (Finai disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760. attending physician for use es the buria Physician/Medicai that initiated events resulting in death) Last Due to (or as e consequence of) is signed by the al Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 9No 1 ☐ Yes 2 ☐ No or Attending Physician; Be 25. Was case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ۲ 1 Impatient 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 1 Naturei Certification: 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation death. 1 Tes 2 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only Σ 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 8 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) St., Chestertown, MD 21620 WUN 223 32. Registrar's Signature 31. Date filed (Month, Dey, Year) State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97

08016

						Ce	rtitica	ite of	Death			Reg. No.		
	Physici /Medi		Decedent's Neme (First, Middle, I ROI	ast) IUALD	BERTRA	ND LEV	ESQU	E		2	Dete of De Month FEB	oth Dey 28 1997	Year	3. Time of Death 8:16 AM
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			National Naval N						Bethe					County
	Funeral Director		123-30-3941	Sex 10XM 2□ F	7. Age (In yrs	. last birthday, Yrs.	Month	ler 1 Year s Deys		Min. A	Dete of Bir (Month, Da pril	th ly, Year) 22,1931	9. Birthpied Country Cana	ce (State or Foreign or) ada
	8 3		Usuel Residence of Decedent 10g. Stete 10b. County		10c. C	ity, Town or L	ocation						100	f. Inside City Limits
	ours after death with the Maryland all, or items 23e or 25s-f show Examiner must be notified at	Funeral Director	New	County		lattsb							100	1 Yes 2 No
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		ne	11. Maritel Stetus	Armed F	edent Ever in torces?	J,S. 13.	Wes Dec	edenf of I	Hispenic Origian, Mexicen,	In? (Specific Puerto Ric	fy Yes or No	- 14. Rac	e - American	n Indian,
Maryland 21215-0020	hours after hursi', or its at Examine	þ	1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes Gi	2□No ve Detes: 1956				Specify:				Whit	
5	72 hours 'natural', dical Exa	Completed	15. Decedent's I (Specify only highest g	Education		16a. Dece	dent's Us	uel Occup	pation during most	of working		16b. Kind of B		
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ore	of Healt I hem Z r other		20e. Method of Disposition		20b.	Plece of Disponentery, cre	osition (A	eme of	ce)		Dete	20c. Location -	City or Town	n, Stete
Ĕ	Pages hent of int: If its iny or o		1 X Buriel 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spec			nt Pet				3-	-4-97	Plattsbu	irgh,	New York
Baltimore,	permit. Pages 1 and Department of Health Important. If New 27 any Injury or other to		21. Signalure of Funerel Service Lice	ensee, #MO	0690				ess of Facility					
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	To the Hospital or A within 24 hours efter To the Funeral Directon pletely filled in b	edical	29e. Certifier (Check only one) 12 Certifying P 2 Medicaf Exs	mfner: On the b	best of my knoasis of examino ner steted.	owiedge, deet etion end/or in	h occurre vestigetion	d et the ti on, In my o	me, dete end opinion, death	l piece, end h occurred	d due to the et the time,	ceuse(s) end me date end plece,	enner as state end due fo th	ed. he cause(s)
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			30. Name end eddress of person and				Print)	NA	CIONAL	NAVA	L MED	ICAL CEN	ITER	
				R, CDR,				BE	THESDA	MD	20889	-5600		
	Sta	ite	31. Dete filed (Month, Day,	1007 32. F	legistrar's Sign	ature	0.1.	9						

AND THE REST OF STREET

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dey 1997 Month **Physician** March 2, Leigh-Anne Lewis 1:00 AM /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 12 Infield Court, North Potomac Montgomery 8. Dafe of Birth (Month, Dey, Year)
July 23, 1 5. Social Security Number 6. Sex If Under 1 Yaar If Under 24 Hrs. 9. Birthplece (Steta or Foraign Country)
Maryland 7. Age (In yrs. lest birthday) Deys 10 M 20 F Months Hours Min. Yrs. 217-70-6304 34 1962 Usuel Residence of Decedant

Funeral Director

the Maryland or 28a-f show Examiner must be notified at therms 23a hours after 'natural', or

Maryland 21215-0020 Hygiere. s 1 and 2 should be filed w if Health and Mental Hygier ltem 27 is marked other th Pages 1 and 2 should important: If Item 27 any injury or other tr altimore, Department of

> **Physician** /Medical Examiner

The law requires that the death certificate be executed ettending physician end for use es the burief-transit Records, P.O. Box 68760. ate has been signed by the e pege 2 should be detached Vital or Attending Physician: director. ō this After Division s after death. the 3 To the Hospital of within 24 hours at To the Funeral Completely filled

10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Montgomery Potomac 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 12 Infield Court, North 20854 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Ricen, etc.) 14. Race - American Indian. Bleck, White, efc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Chef Culinary 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumeme) Be Roger C. Lewis Jean Staub 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Jean Myers - Mother 12 Infield Court Potomac, MD 20b. Plece of Disposition (Neme of 20e. Method of Disposition 20c. Location - City or Town, Steta cemetery, cremetory or other plece) 1 Burial 2 □ Cramation 3 □ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) Pleasant View Memory Gardens 3 - 5 - 97Martinsburg, WV 21. Signature of Junerel Sarvice Licensee 22. Neme end Addrass of Facility Brown Funeral Home Len Martinsburg, West Virginia 23a. Part1. En hr the disaese, or complications that caused the deeth. Do not enter tha mode of dylng, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one causa on each line. Approximate Intarval Between Onset end Deeth Avium - Interceteders h Immediate Cause (Finel diseese or condition resulting in deeth) Due to (or es e consequence of): AIOS Physician/Medical Examin Sequentially list conditions, if any, leeding to immadiate ceuse. Enfer Underlying Ceuse (Disease or injury Due to (or as e consequence of): thet initiated events resulting in deeth) Lest Dua to (or es e consequance of): Pert II. Other significant conditions confributing to death but not resulting in the undarlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Were eutopsy findings available prior to completion of ceusa of deeth? Completed 24e. Wes en eutopsy performed 1□ Yes 2 No 1 ☐ Yas 2 ☐ No 25. Wes cese referred to medical exeminar? Be 26. Pleca of Deeth (Check only ona) Hospifal: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatienf 2 ☐ ER/Outpetienf 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Tima of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be datemined 3 D Sulcide 28a. Plece of Injury - Af home, ferm, streaf, facfory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledga, deeth occurred et the time, dete and place, end due to tha ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et fina firme, defe end place, and dua to the ceuse(s) end menner steted. Medical 29e. Certifier

29c. Licensa number

who complated ceusa of death (Itam 23a) (Type, Print)

1 MD 12 Congressional Ln # 409

32. Registra Significan

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29d. Dafa signed (Month, Dev. Year)

1997

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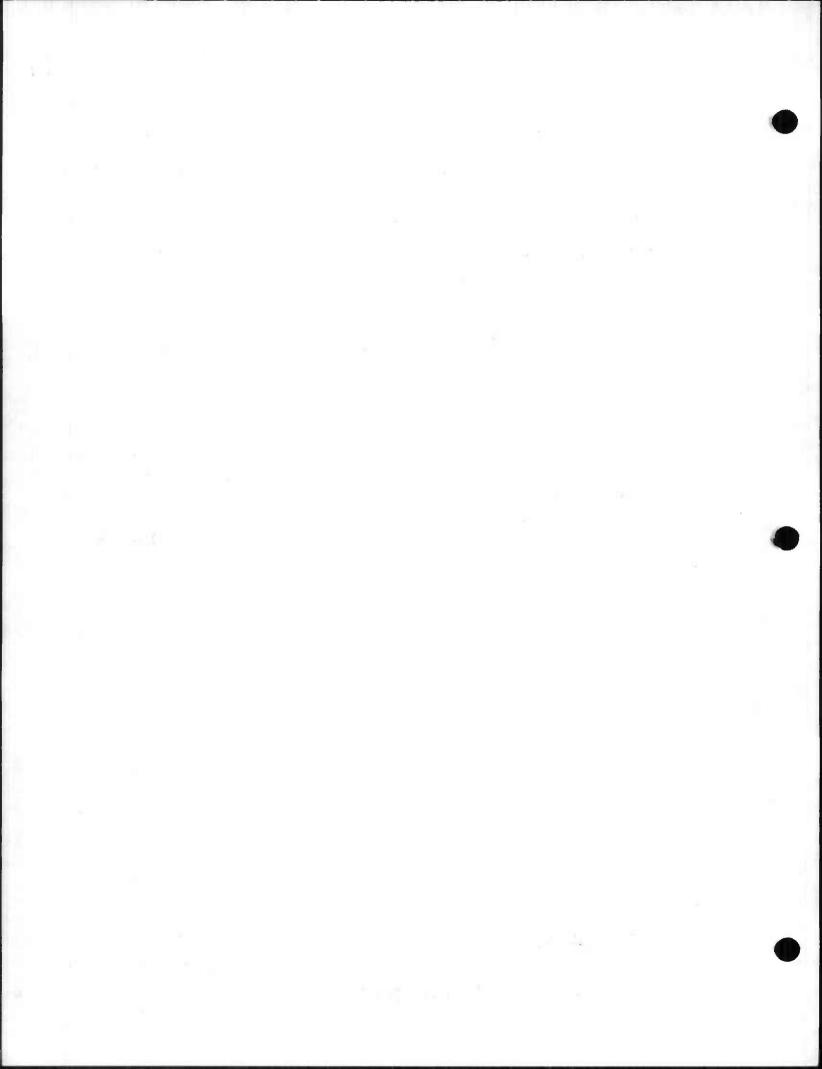
MARCH 03

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State Registrar (Check only

29b. Signatura and fitle of certifiar

°06 1997



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 10:00 pm Maude Μ. Libbey 3, March 1997 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Arnold Anne Arundel Chesapeake Healthcare Center 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Days Hours Min. (Month, Dey, Year) 5. Social Security Number 6. Sex Birthpiece (State or Foreign Country) 1 M 2 X F Yrs. 214-74-5284 Usuei Residenca of Decedent Nov 9, 1891 Maine 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MID Anne Arundel 1 ☐ Yes 2 No Arnold 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21012 USA 110 Church Road 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bieck, White, etc. 1 Never Married 2 Married 1 Yes 2√ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker 12 Home 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Malden Sumeme) Dennis Martin Caroline Dion 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mary McLaughlin/daughter 110 Church Road, Arnold, MD 21012 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) 20e Method of Disposition 20c. Location - City or Town, Stete Lakewood Memorial Park1997 1 X Buriei 2 ☐ Cremetion 3 ☐ Removel from State 6 Jackson, Mississippi 4 Donatton 5 DOther (Specify) Parranco & Sons, P.A. Severna Park Funera ovRitchie Hwy., Severna Park, MD21146 21. Signature of Fugeral Service Lieensee 23e. Part I friter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, and or heart feilure. List only one cause on each line. Approximete intervel Between Onset end Deeth fmmediete Ceuse (Final Pheumoni diseese or condition resulting in deeth) Due to (or es e consequence of) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as e consequence of): thet initieted events resulting in deeth) Last Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown Dementia 24b. Were eutopsy findings evaileble prior to completion of cause of death? 24e. Wes en eutopsy performed? Histus 1□ Yes 20HNo 1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical **Examiner** The lew requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

items 23a or 28a-f show

"natural", or items 23s or 28s-f show

200

permit. Pages 1 end 2 should be filed w Department of Health and Mental Hygier Important: If item 27 is marked other th any filury or other treumatic event, the

death

filed within 72 hours after

Maryland 21215-0020

Saffimore,

P.O. Box 68760.

Records.

Division of Vital Attending Physician: Funeral Director

Completed by

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After this certificate

To the Hospital within 24 hours a To the Funeral D completely filled

Physician/Medical ģ Completed Be 2 Certification:

Examiner

Medicai

25. Wes case referred to medical exeminer? 1 Yes 2 No 27. Manner of Deeth

(Check only

5 Pending Investigation 1 Neturel 2 Accident 3 ☐ Suicide 4 Homicide

6 Could not be determined

Tertifying Phyelcfan: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the cause(s) end menner stated. 29b. Signeture end title of cartifier Try alam Millam

29c. License number

28c. Injury at Work?

1 Yes 2 No

29d. Date signed (Month, Dey, Year) Annyell MD 21451

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

28d. Describe how injury occurred

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Robert Man MILLEL MD 2003 Medical Pky

31. Dete filed (Month, Day, Year)

32. Registrer's Signeture

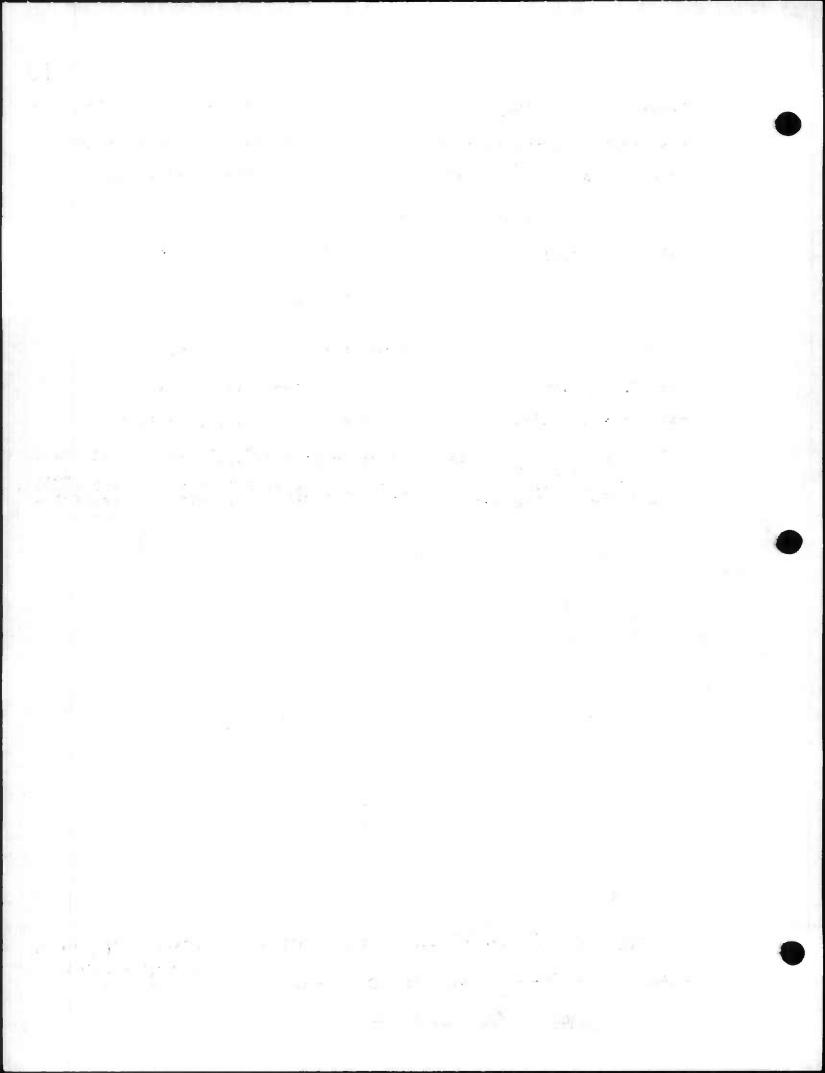
Registrar DHMH 16 Rev 6/95

State

Julia Tavidson Randall

28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



97-1133-017 UNK.#97-054 CMK

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

9/

08019

1. Decedent's Nama (First, Middia, Last) 2. Data of Death **Physician** Month MARCUS TIMOTHY MOTON MARCH 03, 1997 1920 PM /Medical 4e. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner BARRYS HILL ROAD BRYANS ROAD CHARLES COUNTY If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X**) M 2□ F Yrs Director 26 213-88-1032 FEB. 26,1971 WASHINGTON, D.C. Usuel Residance of Dacedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23s or 28s-f shov traumstic event, the Modical Examiner must be notified at 1 Yas 2 No Director MARYLAND BRYANS ROAD CHARLES 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 20616 UNITED STATES 6235 FENWICK ROAD Funeral 12. Was Dacedant Evar in U,S. Armad Forces? 1 ☐ Yas 2 ② No If Yes, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indien, Black, Whita, atc. filed within 72 hours after Hygiene. 1 Navar Marriad 2 ☐ Merriad Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Spacify: by Specify: BLACK 3 ☐ Widowad 4 ☐ Divorced Completed 15. Dacedant's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elemantary/Sacondary (0-12) Collaga (1-4or 5+) RCA RECORDS MARKETING SPECIALIST YEARS permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oths any injury or other traumatic event. 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Be CHARLES H. MOTON JOYCE ELIZABETH MARBRAY MOTON 20 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6235 FENWICK ROAD, BRYANS ROAD, MARYLAND 20616 CHARLES H. MOTON / FATHER 20b. Placa of Disposition (Nema of cematary, cramatory or other pleca) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) HYATTSVILLE, MARYLAND HARMONY MEMORIAL PARK 3/6/97 4 LI Donesia.

21. Signatura of Funarai Service License 22. Nama and Addrass of Fecili THORNTON FUNERAL HOME, P.A. routed ydia C. THORNTON JOHNS MO0583 #3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Onsat and Death **Physician** Mulhiple Injuries

Dualo (or as a consequence of): /Medical Immediata Cause (Finel diseese or condition rasulting in daath) Examiner Examiner physician and the buriel-transit Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Ceuse (Diseasa or Injury that initieted events rasulting in daath) Lest Dua to (or as a consequence of): Box 68760 Physician/Medical Dua to (or es e consequance of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown signed be del Records, p 24b. Ware eutopsy findings evellabla prior to completion of causa of daath? 24a. Was an autopsy performed? Completed page 2 certificate 1 PYas 2 □ No 19Yas 2□ No Division of Vital Be 25. Was casa rafarrad to medical axaminer? 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Dethar (Specify) AT SCENE 1 X Yas 2 □ No this After thi 28a. Data of tnjury (Month, Dey Year) 27. Mennar of Death Certification: 28b. Tima of To the Hospital or Attanding Pi within 24 hours after death. To the Funeral Director: After ti completely filled in by the funera 28c. Injury at Work? 28d. Describe how Injury occurred collision 1 Naturat Injury 5 Panding fired Objet 1 ☐ Yas 2 ☐No -3-97 invastigetion 1801 2 Accidant Driver - auto -6 Could not be detarmined

28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)

28f. Location (Streat and Number or Rural Route Number, City or Town, Stete)

30 17 3 1, W Rd

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the causa(s) and mannar as steted. 6 Could not be detarmined 3 ☐ Suicide 29a, Cartifian (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and piece, and due to the cause(s) and manner stetad. 29b. Signatura and title of certifier 29c. Licansa number 29d. Dete signed (Month, Day, Year) O.C.M.E. MARCH 04, 1997 30. Nema and address of person who completed cause of deeth (ttem 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

rowar

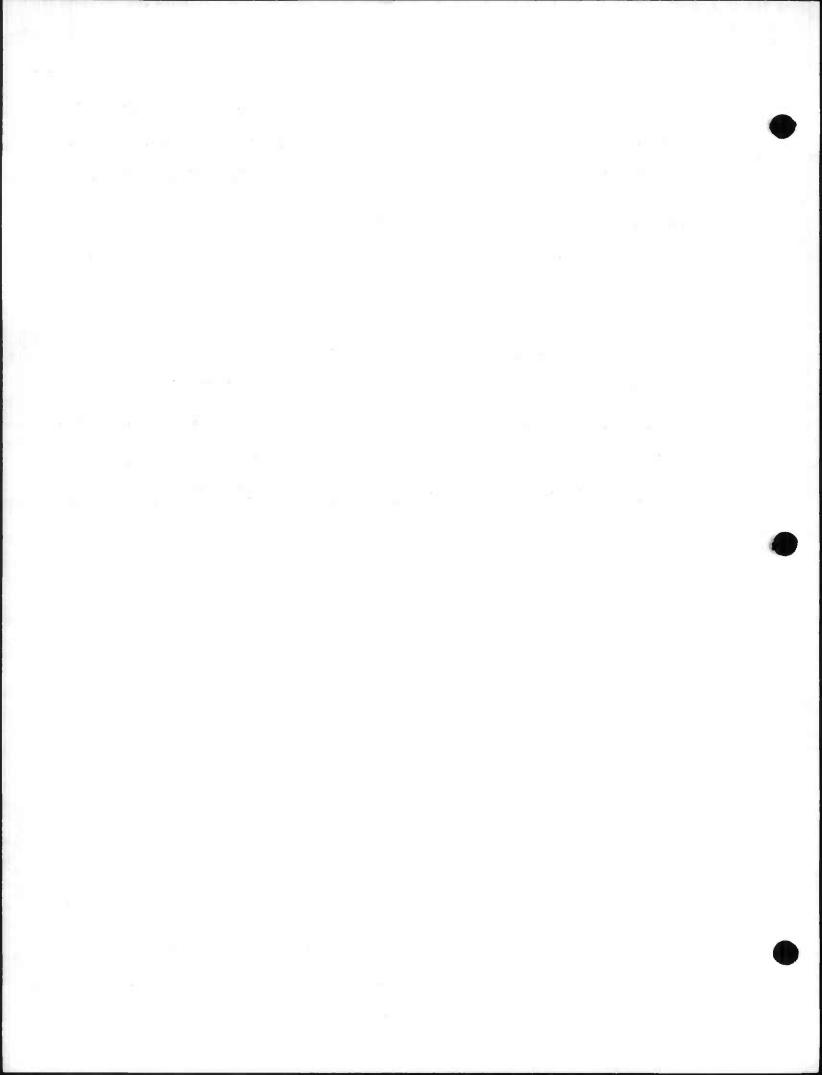
32. Registrar's Signatura

State

Javill

31. Date filed (Month, Day, Year)

MAR 0 5 1997



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Deeth Month 02/28/97 Delsia M. Messenger 3:30am 4a. Facility Nama (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Oakland Garrett Dennent road Manor if Undar 24 Hrs. Hours Min. 5. Social Security Number If Undar 1 Year 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) Birthplace (Stata or Foraign Country) WV . 1 M XXF Davs Months 235-44-3883 88 2/24/1909 Usuel Rasidance of Decadant 10a Stata 10b. County 10c. City, Town or Location 10d. insida City Limits 1 Yas 2 No WV Preston Terra Alta 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 26764 US Rt. 2, Box 98-B 12. Was Dacedant Ever In U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Giva Yaar or Datas: Was Decedant of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuben, Maxicen, Puarto Ricen, atc.) 14. Rece - American Indian Black, White, atc. 1 Nevar Marriad 2 Marriad 1 ☐ Yas 2 No Spacify: 3 Widowad 4 □ Divorced white Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Spacify only highast grada completed) 16b. Kind of Businass/Induatry Elementary/Secondary (0-12) Collage (1-4or 5+) domestic homemaker 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Virginia B. Taylor Ernest W. Burke 19b. Malling Addrass (Street and Number or Rural Routa Numbar, City or Town, State, Zip Coda) 19e. Informant's Name/Ralationship (Type, Print) Rt. 2, Box 98-A, Eleanor Sines Terra Alta, WV., 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stata cematery, cramatory or other place) 3/2/97 Kingwood, 4 ☐ Donation 5 ☐ Othar (Specify) Hopewell Cemetery 22. Name and Addrass of Facility Arthur H. Wright Funeral Home, 105 Highland ave., Terra Alta, WV., 26764 Do not enter the moda of dylng, such as cerdiec or raspiratory arrast, Approximata Intarval Between Onsat end Death Immediate Ceusa (Final disaase or condition rasulting In daath) Due to (dr as a gonsequance of): Sequentially list conditions, if any, leeding to immadieta ceusa. Enter Undarlying Cause (Diseasa or Injury that initieted avants Dua to (or as a consequence of): Due to (or es e consequence of)

Physician /Medical **Examiner**

b

Physician

/Medical

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Director

Funeral [

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Completed

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Funeral

Director

28a-f 1

Pages 1 and 2 should be filed within 72 hours after ment of Hisath and Mental Hygiene.

ant. If florin 27 is marked other than "natural", or its

Maryland 21215-0020

more,

5 8 Items 23a

Examiner signed by the attanding physician and doe datached for use as the burial-trar To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft completely filled in by the fur

cal

Hospital or Attending Physician: The law requires that the death certificate be executed

this After

Division of Vital Records, P.O. Box 68760,

art II. Other significan	t conditiona con	ntributing to death but not ras	sulting In tha undarlying cau	sa givan in Part i.		23b. Did tobacco usa con 1 ☐ Yes 2 ☐ No	ntribute to the causa of death 3 Probably 4 Unknow
			DC.			24a. Was an autopsy performed?	24b. Ware autopsy findings available prior to completion of cause of death?
5. Was cese rafarrad t	o medical			26. Placa of Da	ath (Cl		15 163 25 160
axaminer? 1 ☐ Yas 2 ☐ No	F	lospital: 1 Inpatient 2	ER/Outpetient 3 DOA	Other			er (Specify)
2 Accidant	☐ Panding Invastigation	28e. Deta of Injury (Month, Day Year)	28b. Tima of injury M	injury at Work?	_	Dascribe how Injury occurr	
3 ☐ Suicide 8 4 ☐ Homicida	Could not be detarmined	28e. Pleca of injury - At h building, atc. (Specif	oma, farm, streat, factory, o	office	28f.	Location (Street and Numb City or Town, Stata)	er or Rural Route Number,

BOX SAI, TERRA Alta, W.Va. 26764

State Registrar Dr. SotierE 31. Date filed (Month, Day, Year)

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

SAVOPOULOS

32. Registrar's Signature alix Davidson Rave

Lynn poulos.

4 1, 7

State of Maryland / Department of Health and Mental Hygiene 08021 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Dey Yeer Month **Physician** EUGENE CLARE MORLEY 02 28 1997 8:04 A.M. /Medical 4a. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 32536 Morris Leonard RD Parsonsburg Wicomico If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth
Months Devs Hours Min. (Month, Dey, Year) 5. Sociel Security Number 6. Sex 1.XM 2□ F 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Deys 229-01-4794 79 Yrs Director 08-11-1917 Pennsylvania Usuel Residence of Deceden 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Wicomico Parsonsburg 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? rs 23a or ... 32536 Morris Leonard Rd 21849 U.S.A. by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No Army If Yes, Give Yeer or Detes: WW11 Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. "natural", or itse dical Examiner 1 □ Never Merried 2 □ Merried Baltimore, Maryland 21215-0020 1 ☐ Yee 2 X No Specify: Specify: White 3 ¥Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) College (1-4or 5+) Accountant Public permit. Pages 1 and 2 should be liter.
Doperment of Heelih and Mental Hype Important: If Item 27 is marked any Injury or other. 17. Fether's Nems (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Thomas 1. Morley 0 Minnie Kimmel 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Morley 32536 Morris Leonard RD Parsonsburg, MD 21849 20e. Nethod of Disposition

1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 20b. Plece of Disposition (Name of cametery, cremetory or other piece) 20c. Location - City or Town, Stete 4 □ Donation 5 □ Other (Specify) Beams Cemetery 3-4-97 Jenner Township. PA 21. Signeture of Funeral Service Licenses 22. Neme end Address of Fedlity 705 E. Main St. CFSP Bounds Funeral Home Salisbury, MD 21804 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Cell Carcinona of Wag Examiner Dua to (or es a consequenca of) Examiner requires that the death certificete be executed physician and the burial-transi Sequentielly list conditions, if any, laading to immediate causa. Entar Underlying Ceuse (Disaese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence ot) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequenca of): 89 use Pert tt. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings aveilable prior to completion of cause of death? 24e. Wes an eutopsy performed? certificate hes 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case reterred to medical examiner? Be 28. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Sestdence 6 Other (Specify) P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner ot Death 1 2 Natural 26a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending Investigation efter deeth. Director: Aft 2 Accident 1 Yes 2 No 6 Could not be detarmined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 24 hours 1) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, end due to the cause(s) end menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) end manner steted. 29e. Certifier Wedical (Check only one) within 2 the 29b. Signeture and hije of certifier 29c. License number 29d. Date signed (Month, Day, Year) TEG. 28, 1997 M.D. 030690 30. Name and address of person who completed causa of deeth (Item 23e) (Type, Print) 145 E. Carroll St., Salisbury, MD. M.D.,

State

Registrar

31. Dete filed (Month, Dey, Year)

32. Registrer's Signeture

FEB 281997 Jalia Davison Randall 1 D

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08022 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death Month Year MADORA MILLS 02 27 1997 3:55 A.M. 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 7738 Quantico Rd. Hebron Wicomico If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. 3-18-1918 5. Social Security Number 9. Birthpiaca (Stafa or Foreign 7. Aga (In yrs. last birthday) 1□M 2 F Maryland 220-01-8606 78 Yrs. Usual Residence of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Wicomico Hebron 10f. Zip Coda 10g. Citizen of What Country? 7738 Quantico Rd. 21830 U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 MNo If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Nevar Married 2 ☐ Married 1 Yes 2 No Specify: 3 ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sitter Nursing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) H. Howard Annie 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robinson 7738 Quantico Rd. Hebron, MD 21830 20b. Piaca of Disposition (Name of camatery, crematory or other piaca) 20a. Method of Disposition 20c. Location - City or Town, State Buriai 2 Cremation 3 Removal from State Hebron Cemetery 3-2-97 4 ☐ Donation 5 ☐ Other (Specify) Hebron. MD 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility 705 E. Main ST. Bounds Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Salisbury, MD 21804 Approximate Interval Between Onset and Death Metastatic Concinona Unknown Primary Origin Due to (or as a consequence of). Dua to (or as a consequence of):

Physician /Medical Examiner

burial-transit

physician s the burial

ate hes been signed by page 2 should be detect

certificate

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

by

Completed

Be

Certification:

P.O. Box 68760,

Division of Vital Records.

Physician

/Medical

Examiner

Director

Funeral

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Completed

10e State

10e. Street and Number

Hermon

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11. Marital Status

Funeral

Director

r than "natural", or items 23e or 28e-f the Medical Examiner must be notifie

filled within 72 hours after of Hygiene. ther then "neture", or item

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If Item 27 is marked other

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

27. Manner of Death

1 Natural

2 Accident

3 ☐ Sulcida

4 Homicide

Immediate Cause (Finai

disease or condition resulting in death)

Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart For lune Chronic Obstructive Pulmonany Disease send Insofficiency 25. Was case referred to medical 28. Place of Death (Check only one) Hospitai: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No

28b. Time of

28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28a. Data of Injury (Month, Day Year)

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of causa of death?

1 Yea 2 40 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Besidence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how Injury occurred

1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. Licensa number

M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 Could not be determined

230690

10 m. D. 105 E. Coroll 5t. 501:5500 MD Masti 31. Date filed (Month, Day, Y1997)
FEB 281997

State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

08023

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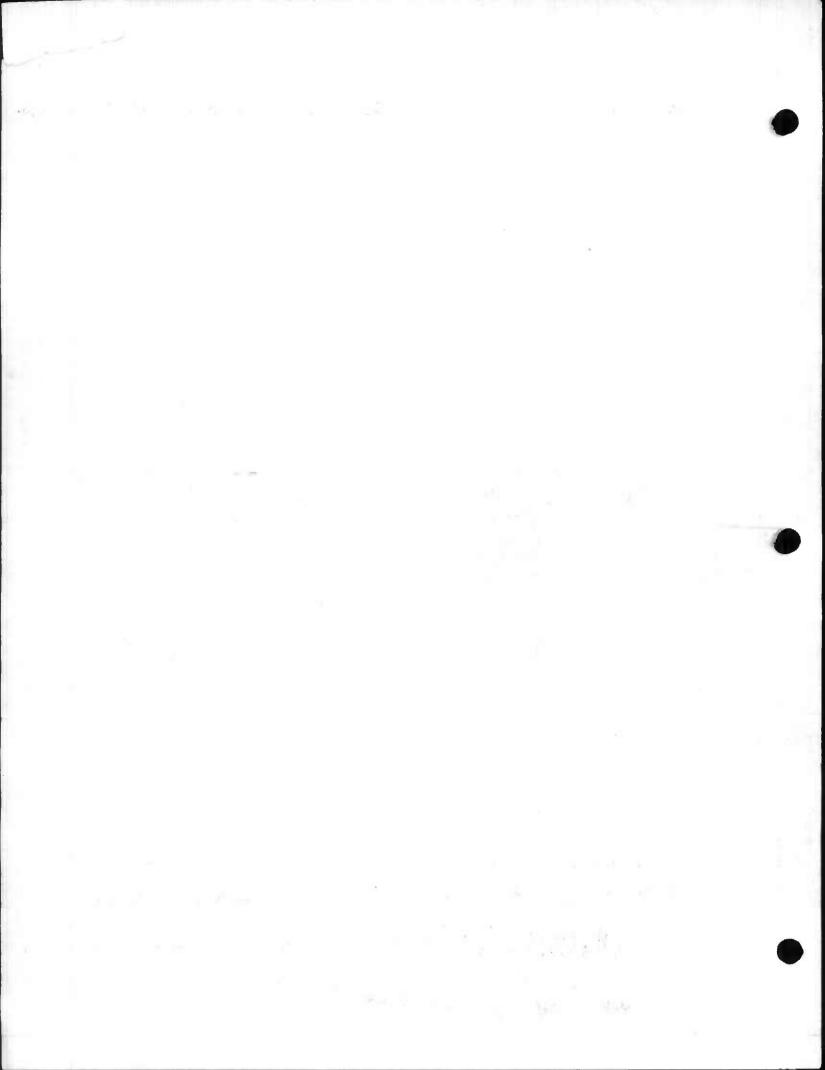
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State of Maryland / Department of Health and Mental Hygiene

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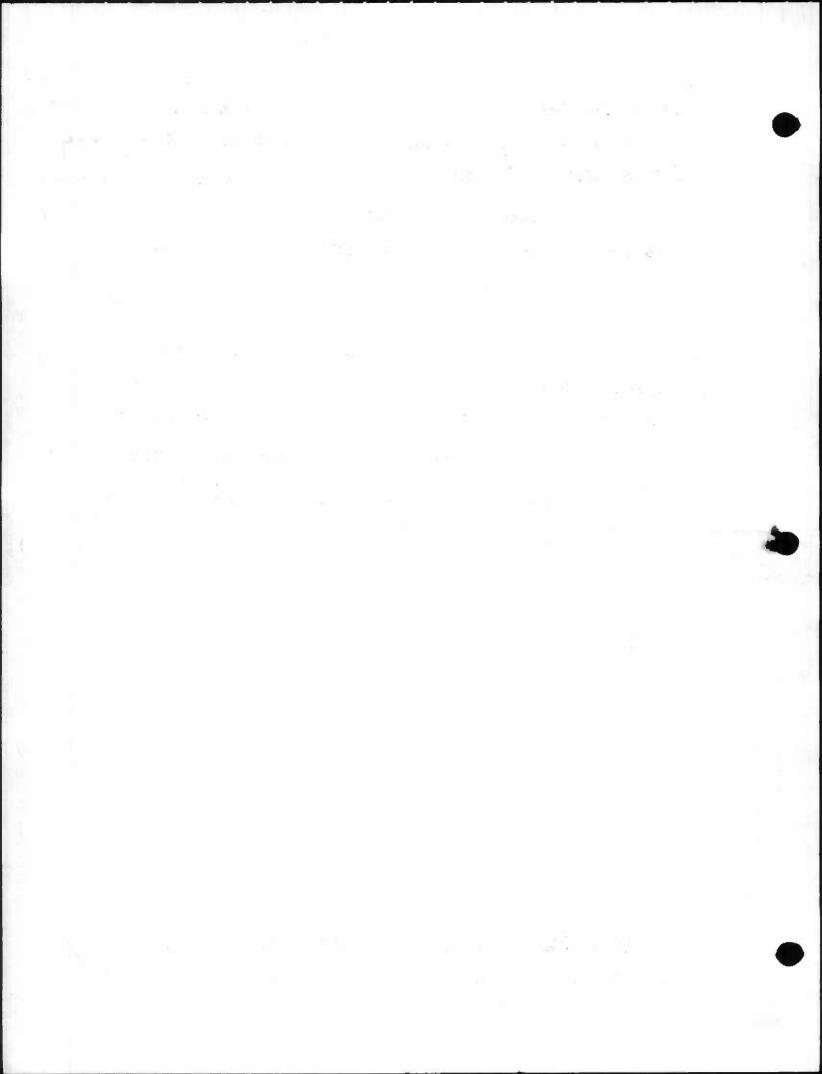
DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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			Agrin	M	D	D43	977		February	28 147	
			30. Name end address of person who com	plated causa of death (Ite	em 23e) (Type, Pr	rint) Da	WS. A	Du Bru	tuis i	mo 21061	
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	egistra	ar	MAR 0 4 1997	Julia Das	idson-Aand	ell.					
HMH 16 R	lav 6/95			~							

State of Maryland / Department of Health and Mental Hygiene

					Certificate of	f Death	Red	. No.		0001		
		1. Decedent's Name (First, Middle, Le	st)				2. Date of Deeth			3. Time of Deeth		
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/Med Exam		4e. Fectlity Neme (If not institution, give	re street end number	r)		4b. City, Town, or Loc	ation of Deeth	4c. County	of Deeth			
		Genesis Elderca	are			Severna	Park	Ann	o Ar	undel		
Funera	1	5. Social Security Number 6. S		Age (In yrs. last birt	hday) If Under 1 Ye	ar If Under 24 Hrs.	8. Date of Birth					
Directo	_	208-18-4733	1 □ M 2 □ KF	95	rs. Months De		(Month, Dey, Y			olece (Stete or Foreign ntry) nsylvani		
у.		Usual Residence of Decadent										
show dat		10a. State 10b. County MD Anne	Arundel	10c. City, Town					1	Od. inside City Limits		
th the Maryland or 28a-f show is notified at	cto		Alunder	Sever	na Park					1 ☐ Yes 2 ☒ No		
E 98	Director	10e. Street end Number			10f. Zip Code		10g	. Citizen of V	Vhat Coun	itry?		
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1020 urs after death with the Marylar sif, or items 23s or 28s-f show Examiner must be notified at	Funeral	11. Meritel Stetus	12. Wes Deceden Armed Forces	t Ever in U,S.	13. Wes Decedent of	f Hispenic Ortgin? (Specuban, Mexican, Puerto R	cify Yes or No-		e - Americ	can indien,		
20 4 4		1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 🛚 tf Yes, Give	No	1 ☐ Yes 250 N			Specify		White		
	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:	:				Specify		white		
and 21215-0 te lited within 72 ha tal Hyglene. d other than "netu event, the Medical	Completed	15. Decedent's En (Specify only highest gra	ducetton ade completed)	16a.	Decedent's Usuel Oct (Give kind of work do	cupetion ne during most of working ired)	g 16	b. Kind of Bu	siness/Inc	dustry		
21215-0020 d within 72 hours at plene. r than "neturel", or the Medical Exam	du	Elementery/Secondary (0-12)	Cotlege (1-4or	5+)				Home				
		6 17. Fether's Name (First, Middle, Last			Homemake	_		THE ASSESSMENT				
	Be					18. Mother's Neme	(First, Middle, Me	iden Sumam	Θ)			
arylar should to rd Manta marked marked	10	Edward Cook					es Fawo					
Man		19a. tnforment's Neme/Reletionship (et end Number or Rural						
- F - F - S - L	es 1 and 2 should of Health and Mau (Rem 27 is marks r other traumatic	Shirley Valenta 20e. Method of Disposition	a/daught			aks Dr., W						
O NOEN		1 ☐ Buriei 2 🛣 Cremetion 3 ☐	Removat from State	cemeter,	Disposition (Neme of cremetory or other p		r 4	c. Location -	,	* -		
thmer tame		4 Donetion 5 Other (Specif			o Cremat			Baltin				
Baltimore, permit. Pages 1 at Department of Has Important. If Item 2 any Injury or other		Barranco Address of Facility, P.A. Severna P.										
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		23a. Pary Enter the diseese, or com	plications that cause one cause on each	ed the death. Do notine.	ot enter the mode of o	lying, such as cardiec or	respiratory arres	t,		Approximate intervei Between		
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/Medica		immediete Cause (Final disease or condition	Hen	te Core	bolorene	or Acced	end			? Days		
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50, se ex clan	E	ceuse. Enter Underlying Cause (Diseese or thjury	C						-			
68/60 flicete be e physician as the buria	dica	that initiated events resulting in deeth) Last	0.	Due to (or es a co	onsequence of):							
X X Sentification	Me		d									
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d by	P	Non humber	Quendo	J-1)x	obeter.	Melhtus	1 □ Yee	200No	3 Prot	bably 4 Unknown		
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r VICAI HEC ysician: The law s certificete hes t director, page 2 s	Be (25. Wes case referred to medical examiner?				26. Piece of Deeth	(Check only one)					
- > 0 V	To	1 ☐ Yes 2 No	Hospitet: 1 ☐ inpati	ient 2 ER/Out	patient 3 DOA	Other: 4 25 Nursing Hom	e 5 Residenc	e 6 □Othe	er (Specify	y)		
ding Ph h. After th		27. Manner of Deeth 1 Natural 5 □ Pending	28a. Date of inju		me of 28c. in	jury at 28	3d. Describe how	injury occurr	ed			
oath.	atic	2 ☐ Accident investigation	1	, , , , , , , , , , , , , , , , , , , ,		☐ Yes 2☐ No						
or Attending effer death. Director: Affer din by the fune	Certification:	3 Sulcide 6 Could not be 4 Homictde determined	289. Place of in	jury - At home, fam tc. (Specify)	m, street, fectory, offic	e 28	of. Location (Street)		ar or Rura	l Route Number,		
o de per per per per per per per per per pe		only of Town, States										
To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier (Check only onle) Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) end manner as stated. Medicat Examiner: On the bests of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner extended.										
the the	Med	one) end menner stated. 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
5 4 5 S			1 1000				290	. Date signed	(Month, I	Day, Year)		
		▶ (vlymae M'	- Halen	acing Uo	Les Do	(16 5 4	3	. 3 . 7	1			
		30. Neme and eddress of person who	completed ceuse of	death (item 23a) (T	ype, Print)	ASA DENA,	1-12-2	1122				
		C. V. CTRIAC. M.D	8109	KITCHIR	AWY P	MINO DIEM	ord d	IIKK				
	ate	31. Dete filed (Month, Day, Year)	32. Regist	rer's Signature	10-1-00-							
Regis	rar	MAR 0 6 19	191 Ju	Mar Haut dage	Marine							

DHMH 16 Rev 6/95

Physician
/Medical
Examiner

Director

25a-f show the Maryla r than "natural", or items 23s or 25s-f show the Medical Examiner must be notified at filed within 72 hours after Hygiana.

21215-0020 Baltimore, Maryland d 2 should be filth and Mental H 7 is marked off pwmit. Pages 1 and 2 should be Department of Health and Mantal Important: if fem 27 is marked i any Injury or other traumatic ev

> **Physician** /Medical Examiner

The law requires that the death certificate be executed attending physician and for use as the burial-transit certificate Mospital or Attending Physician: 124 hours effer death.
 Funeral Director: After this certificaletely filled in by the funeral director, p within 2 To the

Box 68760.

Division of Vital Records, P.O.

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Betty ELIZABETH Niblett February 25, 1997 10:00 AM 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Salisbury Center: Genesis Eldercare Salisbury, MD Wicomico If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months 220-26-8609 Yrs. Maryland Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits Maryland Wicomico 1 ☐ Yes 2 No Director Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 104 Halsey Drive 21804 USA' Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American indian, Bleck, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: þ 3 N Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) 11 Wall paper hanger Self employed 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Joseph Henry Hopkins 2 Nettie Menervia Mitchell 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Richard A. Hopkins Sr./brother 14 W. East St., Delmar, MD 21875 20b. Piece of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 Depetion 5 Other (Specify) Wicomico Memorial Park 2/28/97 Salisbury, MD 21. Sign 22. Name end Address of Fecility M01051 Holloway Funeral Home 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximete Intervel Between Onset end Deeth · ACQUIRED Immediate Cause (Final FACTOR Levers marily disease or condition resulting in deeth) ASSURATION Clemonhotese Examiner Sequentielly list conditions, if eny, leading to Immediete cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): Physician/Medicai Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown ARTIKATES à 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 1 Yes 2 No 1 Yes 2€ No Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2☑ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 2 Accident 1 Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Cartifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29d. Dete signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) and kns 1104 Healthway Dr., Salisbury, MD 21804 Julia 2 Amiles & Rivelath 31. Dete filed (Month, Dey, Year) 7

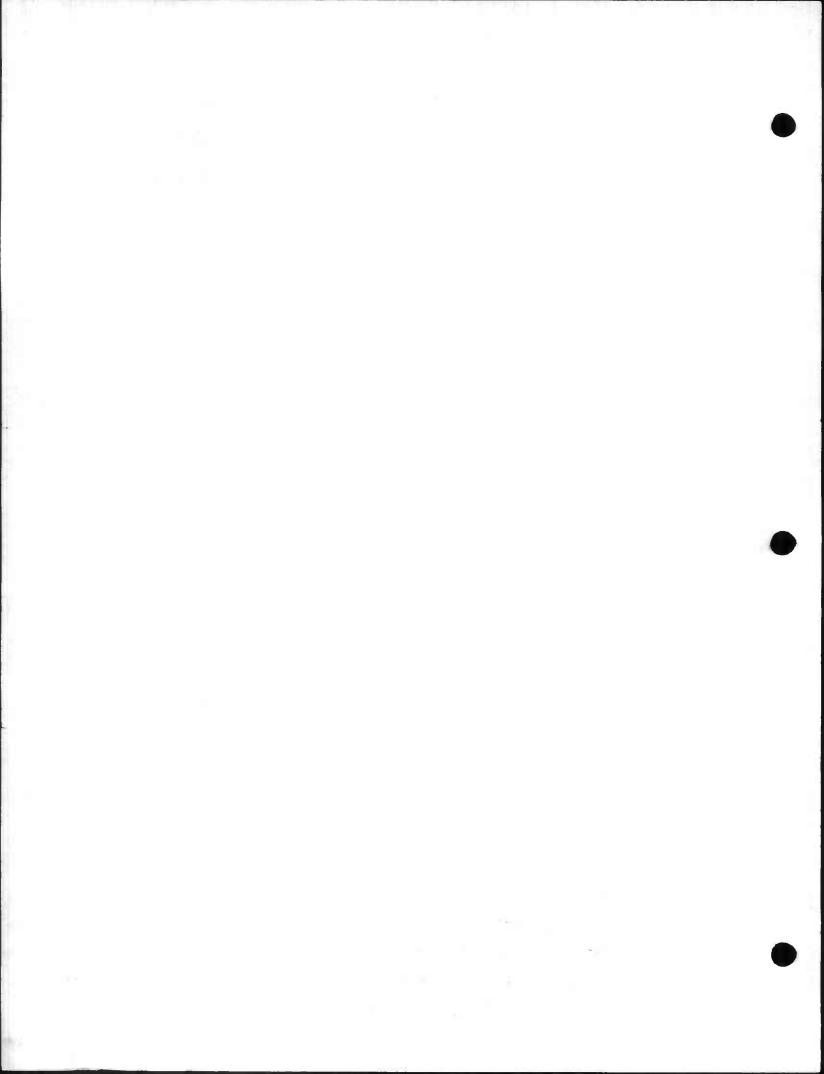
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State of Maryland / Department of Health and Mental Hygiene

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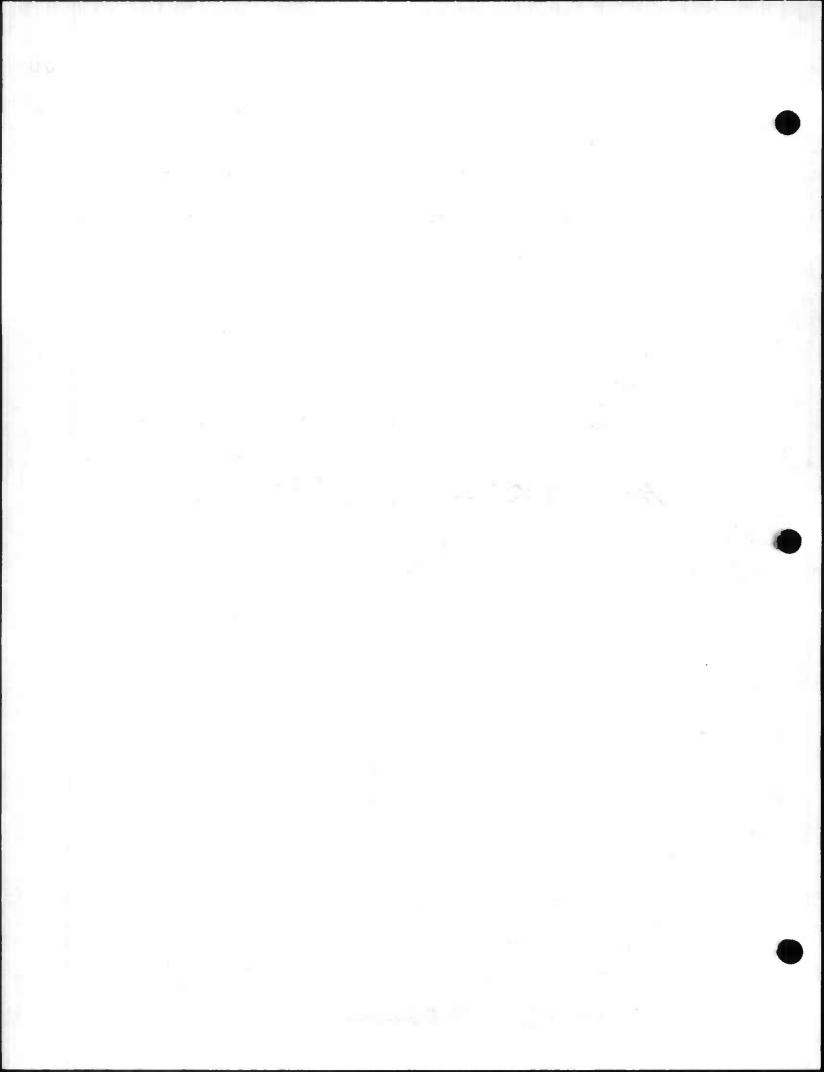
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	30 %		Anne Arunde.		1 Center				Annap	-			e Aru		
	Funeral Director		214 62 2475	Sex 1M2 M 2□F	7. Age (In yrs. last	birthday) Yrs.	If Unde Months	Days		24 Hrs. Min.	8. Dete of Bir (Month, De NOV/9	1,752 1,71952	9. Birth Con Mar	plece (Stete or Formator) yland	aign
	with the Maryland a or 28s-t show Lbe notified at	tor	Usual Residence of Decedent 10a. Stete 10b. County MD Anne 2	Arundel	10c. City, T Seve	own or Lo					7			10d. Inside City Lin 1 ☐ Yes 2 ☑	
	with the 3s or 25s	il Direc	10e. Street end Number 113 Giddings Roa	ad		-	10f. Zip	Code				10g. Citizen o	f What Cou	intry?	
020	hours after death with the Maryla arest, or Items 23s or 25s-4 shot at Examiner must be notified at	by Funeral Director	11. Meritel Stetus 1 ☑ Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced	12. Wes Dece Armed Fo 1 Yes If Yes, Giv Yeer or D	2 🗗 No /8		Wes Dece Il Yes, spe				ecify Yes or No Ricen, etc.)	14. R	eck, White	icen Indien, , etc. hite	
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Maryland	の日間の	To Be	17. Father's Neme (First, Middle, La. Frederick Newco	,							e (First, Middle S Atkin		ime)		
Aar	and		19e. Informant's Neme/Reletionship			19b. Melling Address (Street and Number or Rurel Route No.									
	s 1 and 2 should f Health and Mer item 27 is marks other traumatic		Phyllis Newcomb	(mothe		113 Giddings Road/					1				
imor	Baltimore, permit. Pages 1 a Department of Hes important: if tiem any injury or othe otice.		20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donetion 5 Other (Special Control of Control		Stete cem	etery, crer	metory or o	other pl	matory	7 3	3/1/97	20c. Location			
Balt			21. Signeture of Funerel Service Lic	Theory		A	dvent	Fu		& Cr	rematio	n Servi	.ces		
	Physician		23a. Pert1. Enter the disease, or co shock, or heart feilure. List on	mplications that o y one callse on e	aused the deeth. I ech line.	Do not ent	er the mod	DLLS de of dy	MD 21 ing, such es	cardiec o	or respiretory e	rrest,	1	Approximete Interval Between Onset and Death	
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Records, I	v requires that been signed should be det	by									24a, Was	an autopsy		Vere autopsy finding)8
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f V	2 00	ToE	examiner? 1 Yes 2 No	Hospitel: 1	npatient 2□ER	/Outpatler	nt 3 D	DA O	ther		me 5 Resi		ther (Spec	ify)	
	the fee		27. Manner of Death 1 Neture 5 Pending 2 Accident Investigeti		b. Time of Injury	M	28c. Inju We 1	ury at ork?]Yes 2□		28d. Describe	how Injury occ	urred			
Division	or Attendent efter death Director:	27. Menner of Death 1 \(\sum \text{Neturei} \) 1 \(\sum \text{Neturei} \) 2 \(\sum \text{Accident} \) 1 \(\sum \text{Neturei} \) 2 \(\sum \text{Accident} \) 1 \(\sum \text{Neturei} \) 2 \(\sum \text{Accident} \) 1 \(\sum \text{Neturei} \) 28a. Date of Injury 28b. Time of Injury 4 \(\text{Month}, \sum \text{Dey Year} \) 1 \(\sum \text{Vox} \text{Neturei} \) 1 \(\sum \text{Ves} \text{2} \) 28b. Time of Injury 4 \(\text{Month}, \sum \text{Dey Year} \) 1 \(\sum \text{Ves} \text{2} \) 28c. Injury 4 \(\text{Month}, \sum \text{Dey Year} \) 1 \(\sum \text{Ves} \text{2} \) 28c. Injury 4 \(\text{Month}, \sum \text{Dey Year} \) 1 \(\sum \text{Ves} \text{2} \) 28c. Injury 4 \(\text{Month}, \sum \text{Dey Year} \) 1 \(\sum \text{Ves} \text{2} \) 28c. Injury 4 \(\text{Month}, \sum \text{Dey Year} \) 1 \(\sum \text{Ves} \text{2} \) 28c. Injury 4 \(\text{Ves} \text{2} \) 28c. Injury 4 \(\text{Ves} \text{2} \) 28c. Injury 4 \(\text{Ves} \text{2} \) 28c. 1 \(\text{Injury} \text{4} \) 1 \(\sum \text{Ves} \text{2} \) 28c. 1 \(\text{Injury} \text{4} \)									28f. Location (City or To	Street and Nur wn, Stete)	nber or Ru	ral Route Number,	
	To the Hospital or Attendii within 24 hours efter death. To the Funeral Director: A completely filled in by the formal completely filled in the formal comple	edical C	29e. Certifier (Check only one) 1 Certifying F	miner: On the be	best of my knowled ests of examinetion her steted.	dge, deeth and/or inv	occurred vestigetion	et the t	ime, dete en opinion, dee	d plece, oth occurr	end due to the ed at the time,	cause(s) end r dete end plece	nanner as e, and due	steted. to the cause(s)	
	To the To the	Me	29b. Signature and Hitle of certifier	R.	t 1. 11.		29	c. Licen	se number	~ ?		29d. Dete sign	ned (Month	Dey, Year)	
			30. Neme and address of person who	18 0		a) (Type,	Print)	On a	Jorg Aug	< an	z, Arun	re lo	10	7:50	
	Sta		31. Date filed (Month, Dey, Year)	32. R	Pgistrar's Signeture	וואן ע	2.02	CUC	njejive	= PK	- HOW	THULLS	Val	170/	
	Registr	ar	MAR 0 6 19	31 9	end handagal	malario									



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Month Year JOHN OWENS 1991 3 MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner STELLA MARIE AT MERCY BALTIMORE CITY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1♥M 2□ F Months Days Hours Yrs. **Director** 53 212-42-5389 DEC. 6 1943 MARYLAND Usual Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show notified at 1 X Yes 2 No Directo MARYLAND ANNE ARUNDEL HARWOOD 288-5 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò munt be Items 23a 4332 MUDDY CREEK ROAD 20776 US Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. filled within 72 hours after 1 Never Married 2 ☐ Married altimore, Maryland 21215-0020 8 1 ☐ Yes 2 No Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced "natural". Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuet Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) 렲 9th 0 LABORER SELF EMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental marked WILLIAM OWENS FRANCES PRATT 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 15 Important: If Item 27 is any injury or other to MATILDA DORSEY (SISTER) 22 LAFAYETTE AVENUE ANNAPOLIS, MD. 21401 20a. Method of Disposition 20b. Piaca of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 € Burial 2 Cremation 3 Removal from State CHEWS CHURCH CEMETERY 3/8/97 OWENSVILLE, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee WM. REESE & SUNS MORTUARY, P.A. arri epse 821 WEST ST. ANNAPOLIS, MD. 21401 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediate Cause (Final COLON CANCER METASTATIC disease or condition resulting in death) SCROS Examiner Due to (or as a consequenca of): Examiner The law requires that the death certificate be executed bunel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest Due to (or as a consequence of): Box 68760, physician Physician/Medical the Due to (or as a consequenca of): USB 88 for P.0. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Records, ģ 8 director, page 2 should Completed 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an eutopsy performed? hes 1 Yes 2 No this certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one STELLA MARIS AT MERCY 2 Other: 4 Nursing Home 5 Residence & Other (Specify) HOSPICE 1 Yes 2√2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA filled in by the funeral 27. Menner of Death Certification: 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 128 Naturat 5 Pending investigation s efter death. 2 Accident 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours of To the Funeral DI completely filled in 15 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end pleca, end due to the cause(s) and manner as steted.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mann an 040480 parah 1997 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Belain 5810 ica FERNANDO FERED, 5x110 MIS 2/206 31. Date fited (Month, Day, Year) 32. Registrar's Signature State Julia Davidson-Randalle Registrar

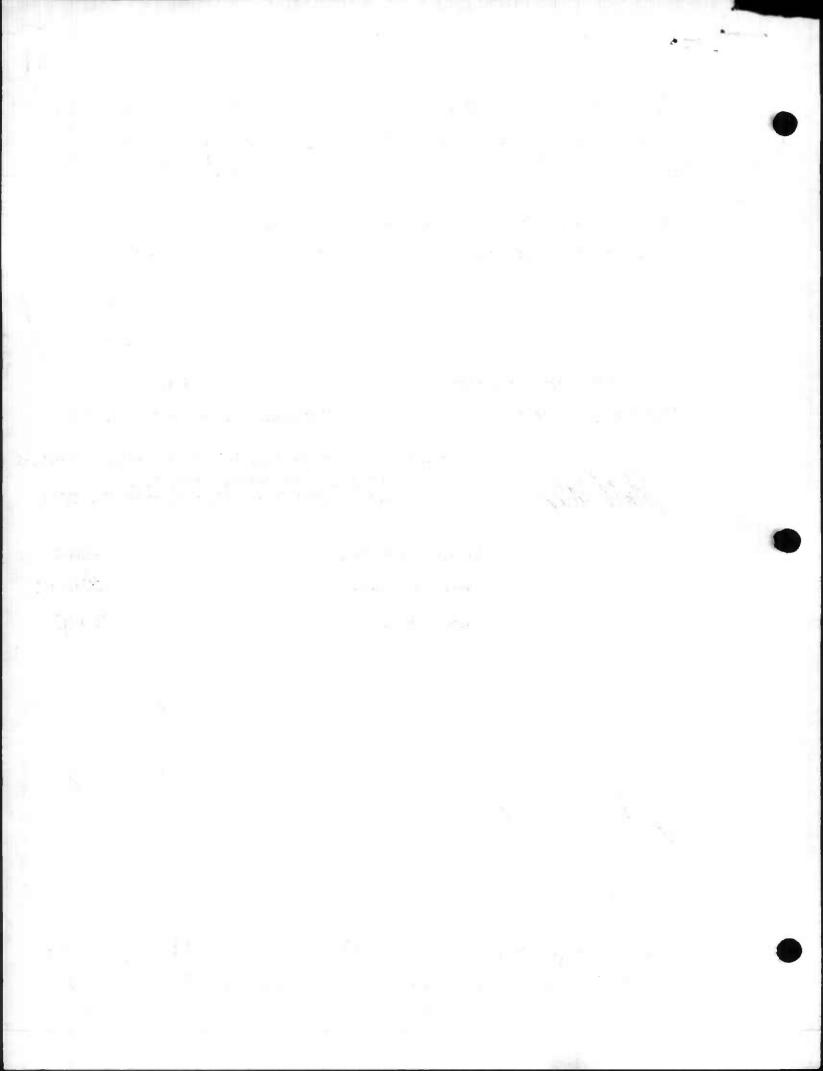
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	15		Cei	rtificate of	Death		Reg. No.		0000	
/slcian	1. Decedant's Nama (First, Middla, La					2. Data of De Month		Year	3. Tima of Death	
ledical	John David	Openshaw				telon	Mary 211	1997	1730	
aminer	4a. Facility Nama (If not institution, give	4 4 4 4 4 4				or Location of Deat	h 4c. County			
	The Johns 5. Social Security Number 6.5		SOLTO	If Undar 1 Year	Baltin 11 Undar 24 H	OR CITY	dh	N/A	an /State or Formin	
eral tor	215-43-1796 Usual Residence of Decedant	Sax 7. Aga (In yrs	Yrs.	Months Days	Hours M	in. (Month, Or Nov. 9	th y, Year) 1994	Mary	aca (Stata or Foraig ry) / Land	
To Be Completed by Funeral Director	10a. Stata 10b. County	10c. C	ity, Town or Lo	ocation				10	d. Insida City Limit	
Director	Maryland Anne Ar	undel	Annapo	lis					1 Yas 2□N	
Dire	10e. Street and Number			10f. Zip Code	0.1		10g. Citizan of \		у?	
Funerai	104 Duke of Glouc		16 401	2140		/O/4-V	US.		- 1- 1/	
E E	11. Maritel Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedant Evar in U Armed Forces? 1 ☐ Yas 2 ☐ No	7,5.	Was Decedant of H If Yas, specify Cubi	en, Maxican, Pu	arto Rican, etc.)	Blee	a - Amarica ck, Whita, at		
by	3 ☐ Widowed 4 ☐ Divorced	If Yas, Giva Yeer or Datas:		1□ Yas 2\ No	Specify:		Specify	Whit	ce	
Completed	15. Decedant's E (Specify only highast gra	ducation	16a. Dece	dant's Usual Occup	pation	unrich a	16b. Kind of B	usiness/Indu	ustry	
nple	Elementary/Secondary (0-12)	Collega (1-4or 5+)	lifa.	kind of work dona DO NOT usa retired	d) most of w	vorking				
ပိ	0			N/A				N/A		
Be	17. Fathar's Nama (First, Middle, Last	ton Openshaw				lama (First, Middle, Maidan Sumama) ilv—Ann Heiner				
2	19e. Informant's Name/Reletionship (10h Mailie	a Address (Ctreat		ily-Ann Heiner Rural Routa Number, City or Town, State, Zip Coda)				
	Lily-Ann Opensha		104 D	uke of G	louceste	er St. An	napolis	State, Zip Coda) Md. 21401		
	20a. Mathod of Disposition	Data	20c. Location -							
Important: If Item 27 is marked any Injury or other traumatic elega.	1 X Buriai 2 ☐ Cramation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif			natory or other place.		ry 3_4_0	7 Crown		e, Maryla	
9	21. Signatury 5 Suneral Service May	1999	29	Nama and Addre	ss of Eacility	1 II	CLOWIE	, svitte	, maryra	
ä	D 1/Ant 1 //1/6	2	2	973 Solom	nons Tel	uneral H	ome, P.A	A.	21037	
	23a. Bart1. Enter the disease, or com shock, or heart failure. List only	plications thet caused the dea	th. Do not ant	ar tha moda of dyir	ng, such as card	iac or respiretory a	rrasi,		Approximata Intarval Batween	
n	and of float failure car only	one causa on agon me.							Onsat and Death	
al er	Immediate Ceuse (Final disaasa or condition	Brai	nn	eath				<	thous	
	resulting in death)	Dua to (or as a consec	4						
nin.		b. (eret	mal	Edoma				-	50 hours	
Examiner	Sequentially list conditions, if any, leading to immediate causa. Entar Underlying	Dua to (or es e consag	uanca of):				1	36 hours	
edical	that initiated avants	c. Lue	or as a consag	ine					(days	
₹	rasulting in daath) Last	d	or as a correaq	uarica orj.						
Physician	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	ndarlying cause giv	ven in Pert I.	23b. Did	tobacco use co	ntribute to t	the cause of deeth	
by Ph						10	Yes 27 No	3 Probe	ably 4 Unknow	
Completed by Physic						24a. Was	an autopsy ormed?	avai	re autopsy lindings leble prior to splation of cause	
dwo						40	va. office		aath?	
Be C	25. Was casa ratarred to medical				26 Place of D	eath (Check only o		10	Yas 2 No	
To B	axaminer? 1 ☐ Yas 2 ☑ No	Hospital: 1 Inpatiant 2	ER/Outpatien	t 3 DOA Oth	OF.	Homa 5 Rasi		ar (Specify)		
	27. Menner of Death 1 ☑Naturel 5 ☐ Panding	28a. Data of injury (Month, Day Year)	28b. Tima of Injury			1	how injury occur			
catic	2 Accidant Invastigation	n	,,		Yas 2 □ No					
Certification:	3 ☐ Suicida 6 ☐ Could not b 4 ☐ Homicida datarminad		oma, farm, str	eat, factory, office		28f. Location (City or To	Straet and Numb wn, Stata)	er or Rural	Route Number,	
edical	(Check only 2 Madical Exer	niner: On the basis of axamina and mannar stated.	curred at tha tima,	date end plece,	and dua to t	ha causa(s)				
	29b. Signatura and titla of cartities	Λ		29c. Licans	a number		29d. Pata signe	d (Month, Di	ay, Year)	
M	11		MCI	127		Lebour	16,	1907		
W	Dano Cato	30. Nama end address of person who completed causa of deeth (Itam 23a) (Type, Print)								
Medical Certif	30. Nama end address of person who	completed causa of death (Itar	m 23a) (Type,	Print)		(0	m ~	11611	
Me	0.	completed causa of deeth (Itar	m 23a) (Type,	Print)	ing Has	pital	Battin	1016 1	mo	

DHMH 16 Rev 6/95



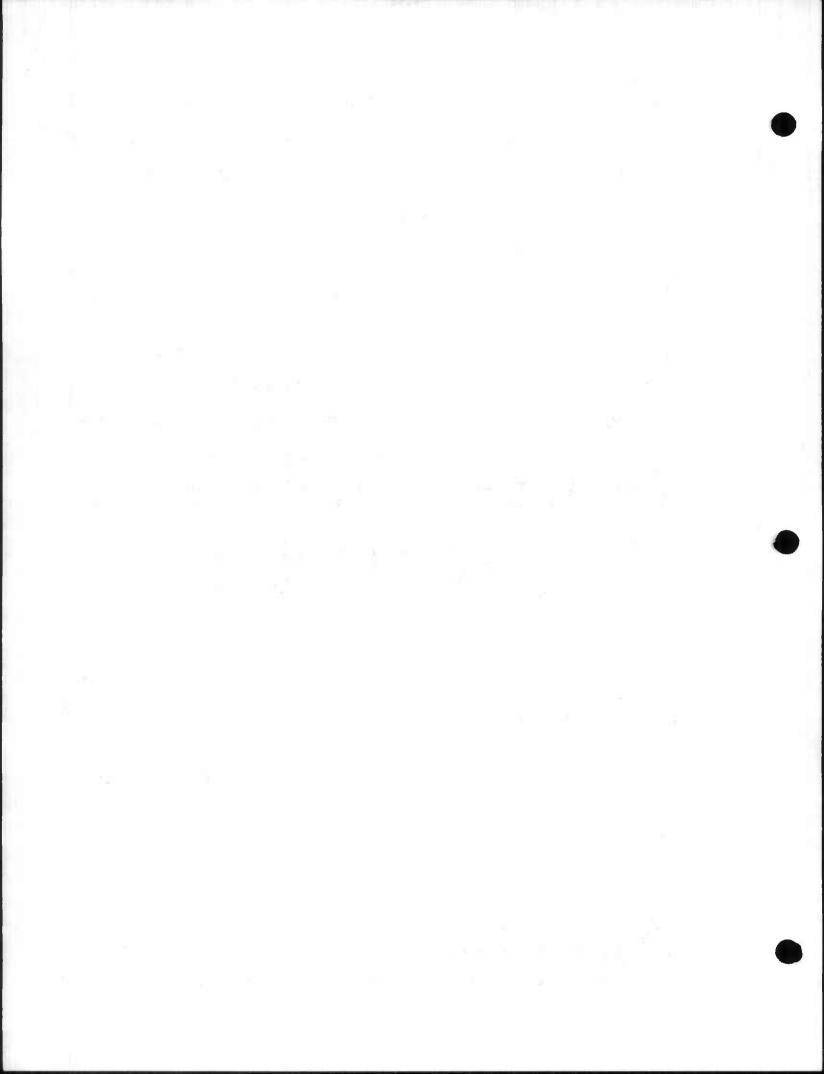
State of Maryland / Department of Health and Mental Hygiene 08032 Items: 23 part I, II per MEO G-746 4/1/97 rebCertificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Deta of Death **Physician** 28 Pay FEB. 1997 FLOYD PRICE 2:20 PM /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 1557 SOUTHVIEW DR. OXON HILL PRINCE GEORGE 6. Sax_ 1 ☑ M 2 ☐ F If Undar 1 Yaar If Under 24 Hrs.
Months Deys Hours Min. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Deys Yrs. 51 213-46-6165 Director 23,1946 MARYLAND JAN. Usual Residence of Dacedant 10a State 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Insida City Limits the Marytar 1 Xas 2 No Director MARYLAND PRINCE GEORGE OXON HILL 10e. Street and Numbar 10f. Zip Coda 10g. Citizen of What Country? 8 the Medical Examiner must be **#1557 SOUTHVIEW DRIVE** 20647 Herne 23a UNITED STATES Funeral 12. Was Dacedanf Evar in U,S. Armed Forces? 1 Yas 2 No If Yes, Give 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Bieck, Whita, atc. Nevar Married 2 Married 8 Baltimore, Maryland 21215-0020 1 Yas 2 No Specify. Specify: BLACK þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Hygiene. 12TH GRADE ENGINEER GOVERNMENT 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) 2 should be fl and Ments! H marked JAMES ELMER PRICE ALINE CHRISTINE THOMAS PRICE permit. Pages 1 and 2 sh Department of Health and Important: if flew 27 is ma any injury or set 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Code) HAMPTON PRICE / BROTHER 8821 OLIVER PLACE, NANJEMOY, MARYLAND 20b. Piace of Disposition (Nama of cametery, cramatory or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stata 1 ABuriel 2 Cramation 3 Ramovai from Stata 4 Donation 5 Othar (Spacify) HOPE CHURCH CEMETERY 3/6/97 NANJEMOY, MARYLAND 21. Signature of Funaral Sarvica Licansee 22. Nama and Addrass of Facility
THORNTON FUNERAL HOME, P.A. THORNTON JOINSON M00583 3439 LIVINGSTON ROAD, INDIAN HEAD, MD. INDIA C. 23e. Part 1. Entar the disaasa, or complications that causad tha daeth. Do not antar tha moda of dying, such es cardiac or respiretory errest, shock, or haart failure. List only one causa on each line. **Physician** DIABETAC KETOACIDOSIS /Medical immediata Cause (Finel diseasa or condition resulting in daath) Examiner Due to (or as a consequence of) Sequantially list conditions, if any, laading to immediata causa. Entar Underlying Causa (Disaasa or injury that initiated avents rasulting in daath) Last Dua to (or es e consaquance of): physician s the burial Box 68760. death certificate be Physician/Medical Dua to (or as a consequence of): attending ŏ Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. the 23b. Did tobacco use contribute to the cause of death? Unknown signed by 1 Yes 2 No 3 Probably Records, à 24b. Wara autopsy findings availabla prior to complation of cause of death? Completed 24a. Was an autopsy HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE paga 2 Pas S certificate Yes 1 Yas 2 No 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was casa referred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: Othar: 4 ☐ Nursing Home 5 XResidence 6 ☐ Othar (Specify) 1 XYas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Date of Injury (Month, Dey Year) Certification: 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yas 2 ☐ No invastigation 6 Could not ba datarminad 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) in by 4 - Homicide 29a. Cartifiar 1 Certifying Physician: To tha bast of my knowladga, daath occurred at tha tima, data and piece, and dua to tha causa(s) and manner as sfeted. (Check only 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ature and title of certifier 29b. Sig 29c. License number 29d. Date signad (Month, Day, Year) O.C.M.E. MARCH 01, 1997 rass of parson who completed causa of daath (Item 23a) (Type, Print) CARON 40 DC 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signetura

Julia Studior Randall

State Registrar

MAR 0 5



State of Maryland / Department of Health and Mental Hygiene

97 08033

							Cer	titica	te of	Death			Reg. No.		
	Dharata		1. Decedent's Neme (First, Mid	die, Last)								2. Dete of De Month	ath Dey	Yeer	3. Time of Death
Į	Physic /Medi		PRISCILLA	ELL	LEN		PEF	DUE				02	23	97	1035
$\}_{i}$	Exami		4a. Fecility Neme (If not instituti	on, give street a	nd number)					4b. City, To	wn, or L	ocation of Deeth	4c. Count	y of Death	
			PENINSULA REGI	ONAL ME	DICAL	CENTE	R		5	SALISE	BURY		WICON	1ICO	
	Funeral		5. Sociel Security Number	6. Sex		e (In yrs. las	t birthday)	If Unde	r 1 Yeer Deys	If Under Hours	24 Hrs. Min.	8. Dete of Bir (Month, De	th v Year)	9. Birthp	piece (State or Foreigntry)
н	Director		214-36-6183	1□M 2	S F	59	Yrs.	WORKIS	Deys	rious	WIIII.	04-09-	37		yland
	P.		Usuel Residence of Decedent			1.0 0: 7		-1							
	show	-	10a. Stete 10b. Coun	•		10c. City, T								1	IOd. Inside City Limit
	M earl	cto		comico			Sali	sbury	У						1 Yes 2 N
	igh th	Director	10e. Street and Number					10f. Zi	p Code	801			10g. Citizen of	What Cour	ntry?
	ath w	Ta.	218 Hazel Ave	.									USA		
	er de	Funeral	11. Meritel Stetus	Arm	s Decedent led Forces?		13. V	Ves Dece Yes, spe	edent of the cify Cub	Hispenic Ori en, Mexicar	igln? (Sp n, Puerto	ecify Yes or No Rican, etc.)	- 14. Re-	ce - Americ ck, White,	
20	hould be filed within 72 hours after deeth with the Maryland d Mentel Hyglene. marked other than "natural", or Nema 23a or 28a-f show matic event, the Medical Examiner must be notified at	by F	1 Never Merried 2 Me	If Yo	Yes 2 🔀 l	No	,	□ Yes	2 🔯 No	Specify:			Specia	y:	
8	ural	D	3 ☐ Widowed 4 ☑ Divorce		or or Detes:										ITE
15	n 72	Completed	Specify only high	nt's Education est grade compl	leted)		6a. Deced	kind of wo	ork done	pation during mos d)	t of work	ing	16b. Kind of B	usiness/in	dustry
12	within	m m	Elementery/Secondery (0-12)	Coli	ege (1-4or 5	5+)				<i>(a)</i>			22.14		
9	filed with Hyglene. ther ther		11. Father's Name (First, Middle	Last)	•		У1	sab1	ea	18 Moth	ar's Nem	e (First, Middle,	N/A Maiden Sumer	me)	
an	2 0 0 ×	Be C	John State								Alic	A . 12 - 24 - 2	liams	,,,,,	
Maryland 21215-0020	whould be filed withing Manual Hyglene.	To			n#1		10h Mailin	a Address	o (Ctron					State 7in	Cada
Ma	12 8 8 1	19e. Informent's Neme/Relationship (Type, Print) Julia A. Senkbeil/daughter 19b. Mailing Address (Street and Number of P.O. Box 26, Quant												, State, Ziji	, cooe)
e,	Pages 1 a nent of He ant: If item ury or othe		20e. Method of Disposition			20b. Plec	e of Dispo	sition (Ne	me of		11020	Dete	20c. Location	- Clty or To	own. Stete
9			1 Burial 2 ☐ Cremettor		from Stete	cem	etery, cren	netory or	other ple						
Baltimore,			4 Donation 5 Other (M	3/05/	nghill		_	ruens ess of Fecili		2/26/97	Hebron	, MD	
Ba	permit. Departr Imports any Inji		21. Sprange or remain service	DA U		1051	22			y Fun		Home			
_		ш	Navid	A. 6	ompoo	N		501	Sno	w Hil	1 Rd	., Sali		MD 21	
			23e. Pert1. Enter the diseese, shock, or heert feilure. Li	or compilcations at only one caus	thet faused e on eech lin	the deeth. I ne.	Do not ente	er the mo	de of dy	ng, such es	cardiec	or respiretory e	rrest,		Approximete Interval Between
	Physician /Medical		lean data Cours (First											1	Onset end Deeth
1	Examiner		immediete Ceuse (Finei diseese or condition resulting in deeth)	e CI	RONIC	OBST	RUCTI	VE L	JNG	DISEA	SE				YEARS
Ċ.		7				Due to (or a	s e conseq	uence of)):						
	led 1sit	Examiner		b											
	certificate be executed ding physician and ise as the burial-transit	хаг	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury			Due to (or ea	s e conseq	uence of)	:					i	
68760,	be e gician burit		Cause. Enter Underlying Cause (Disease or injury that initiated events	c										i	
687	icate phys	Medical	resulting in deeth) Last			Due to (or es	e conseq	uence of):	:					1	
X				d											
ă	for ette	Physician	Destil Osternaturalisada estado	1			- I - II - I					l con Dist			
o.	that the de ad by the detached	ys	Pert ii. Other significant condit	ions contributing	g to death bi	ut not resultir	ng in the ur	nderlying	cause gi	ven in Part	1.				o the cause of deat
0	es thet igned b		OSTEOARTHRITIS	}								םי ו	Yes 2 No	3 M Pro	bebly 4 ☐ Unkno
Records,	lew requires thet the as been signed by the	d by										24e. Wes	en eutopsy	24b. W	ere autopsy findings
00	v raquire been si should	Completed										perfo	med?	ev	raliable prior to impletion of cause
Re	0 - 0	d L										_			death?
	ician: The l certificata he rector, page											10		1(Yes 2 No
Vital	Physician: this certific	Be	25. Wes case referred to medic examiner?	Hospitel:	_				Ot	hor		h (Check only o			
o	£ 5 5	: To	1 X Yes 2 No 27. Menner of Deeth		1 inpatte		Outpation b. Time of		UA]	4 🗆 NI	ursing Ho	ome 5 Resident	dence 6 D0ti		(y)
	the une	Certification:	1 ☑ Neturai 5 ☐ Pend		(Month, De	y Year)	injury	м	28c. inju Wo	rk?]Yes 2□	No	200. Describe	iow injury occu	1100	
S	or Attending after death. Director: After in by the fune	ica	3 ☐ Suicide 6 ☐ Could	not be	Place of inju	ury - At home	farm etr			,,,,,,	-	28f Location (Street and Num	her or Rur	al Route Number,
Division	or Attendi after death Director: A	erti	4 Homicide deter	mined 200.	building, etc	c. (Specify)	, ιαιτιί, οιιτ	301, 100101	y, omos			City or To		207 07 1107	ar riodio rvanibor,
_	Hospital 24 hours Funeral stely filled		29e. Certifier 1□ Certify	ing Physician: 1	To the best of	of my knowle	dae deeth	Accurred	at the ti	me dete er	nd pleas	and due to the	cause(s) and m	annar se e	teted
	Hospita 24 hours Funeral etely filled	edical		i Examiner: On		exeminetion									
	To the Hospital or Attantivitin 24 hours after deal Youthe Funeral Director; completely filled in by the	Me	29b. Signature end title of certif					29	c. Licen	se number			29d. Date signi	ed (Month,	Day, Year)
	- > - O		21-	0 1	1 1		_	_	005				00 0=	-	
	/		30 Name and diditions of second		rel	e.p.M			0359	19			02-25-9)7	
	5		30. Neme and address of perso					•	D -	12777	TINT	MD 0300	. 7		
	Sta	at c	JOHN T. BULKEL 31. Dete filed Month. Reput Print			PINE		KUA	ט, כ	PALISE	UKY	MD 2180	1		
	Registi		LED % D	131	out at the	William F. Co.	- Conf								

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Deeth

FEB.

08034

3. Time of Death

10:45A.M.

			1. Decedent's Nem	ne (First, Middle	e, Last)						
	Physic /Medi			PAULIN	ΙE		Τ.]	PARS	ONS
	Exami		4e. Facility Neme (gure street end no SURG ROAD	um <i>ber)</i>					4b. City PAR
	Funeral Director		5. Sociel Security N 216-07-8		6. Sex 1 ☐ M 2 🖾 F	7. Age (in yrs. last	birthday) Yrs.	if Under Months	1 Yeer Deys	If U
	2 *		Usuel Residence o	f Decedent		-			,		
	M M		10e. Stete	10b. County		10c. City, Town or Location					
	May affed	tor	MD.	WICC	MICO		PAF	RSONS	BURG		
	th with the 23s or 28 set be not	al Director	10e. Streat end Nu 7667 P.		SURG ROAD				10f, Zip	Code 2184	9
020	vurs after dear aft, or fleme: Examiner ms	by Funera	11. Maritel Stetus 1 □ Never Merr 3 □ Widowed		II Von C	orces? 2 📉 No ive	er in U,S.	If	Ves Deced Yes, spec	cify Cub	lispani en, Me Spe
2	72 ho	ompleted	(Spec	15. Decedent	t'a Education of grade completed)	16	Se. Deced (Give I life. D	ent's Usue	el Occup	eation during
2121	21215-002(d within 72 hours a piere. r than "netural", o		Elementery/Second 12	ondery (0-12)	College	(1-4or 5+)		ife. E EAMS			d)

4b. City, Town, or Location of Deeth 4c. County of Death PARSONSBURG WICOMICO if Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Day, Year) APRIL 18 1915 Birthplece (Stete or Foreign Country) MD.

24 Dey

pamilt. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "matural", or ite

b

Physician /Medicai

Examiner

the attending physician and ned for use as the burisi-tran

igned by

#

Attac

at or Attend a after death if Director: /

hours

25 To the T

Box 68760

P.O.

Division of Vital Records,

altimore, Maryland 21215-0020

Completed

10

Examine

Physician/Medical

þ

Completed

Be

To

Certification:

edical

10d. Inside City Limits 1 ☐ Yes 2/☐ No

U.S.A.

10g. Citizen of What Country?

1997

13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No

14. Rece - American Indien, Bleck, White, etc. Specify: WHITE

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) SEAMSTRESS

16b. Kind of Business/Industry

WILLARDS, MD.

FACTORY

17. Father's Neme (First, Middle, Last)

TUBBS LORENZA

18. Mother's Neme (First, Middle, Melden Surneme)

CLARA WILKINS

19a. Informent's Neme/Relationship (Type, Print)

GENEVA JONES-DAUGHTER 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece)

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7653 PARSONSBURG ROAD, PARSONSBURG, MD. 21849

2/27/97

20e. Method of Disposition Burial 2 Cremetion 3 Removel from Stete
4 Donetion 5 Other (Specify)

NEW HOPE CEMETERY

20c. Location - City or Town, Stete

21. Signature of Fungral Service Licansee

22. Name end Address of Fecility

BOUNDS FUNERAL HOME, SALISBURY, MD.

21804

Immediate Cause (Final disease or condition resulting in death)

Cerebovascular Accident Due to (or es a consequence of):

beral Voscular Due to (or es e consequence ol):

23a. Paper. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, whock, or heart leilure. List only one cause on each line.

Duno

Zwko.

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Last

2 Accident

3 ☐ Suicide

4 Homicide

Due to (or es e consequença of)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown 24a. Wes an eutopsy performed?

1 Yee 2 No

24b. Were autopsy lindings evelleble prior to completion of cause of deeth? 1 Yes 2 No

25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one)

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Hospitel: 1 Inpatient 2 ER/Outpetlent 3 DOA 1□ Yes 2ENo 27. Mennes of Deeth 28e. Dete of injury (Month, Dey Year) 1 Naturei 5 Pending investigation

28c. Injury et Work?

Other: 4 Nursing Home 5 PResidence 6 □Other (Specify) 28d. Describe how injury occurred

28b. Time of Injury 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and pieca, and due to the cause(s) end menner stated.

29b. Signature and title of certifler water

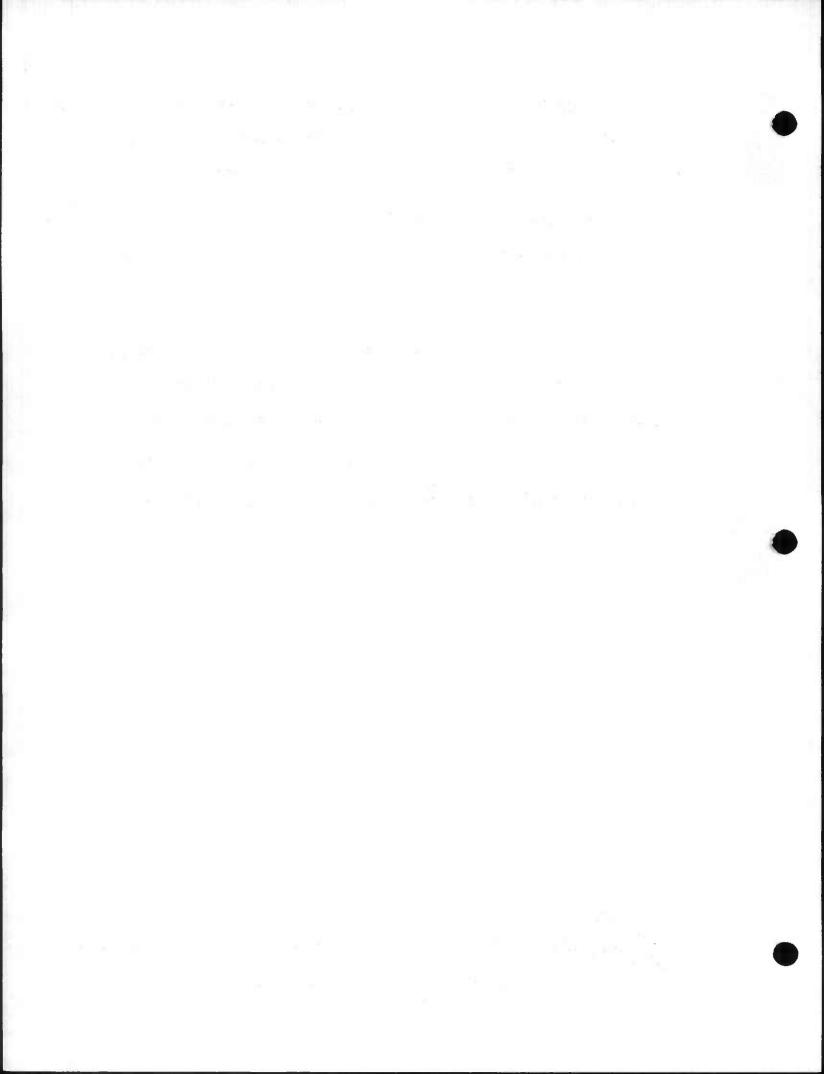
6 Could not be determined

29c. License number

29d. Dete signed (Month, Dey, Year)

eddress of person whe completed cause of deeth (Item 23a) (Type, Print)

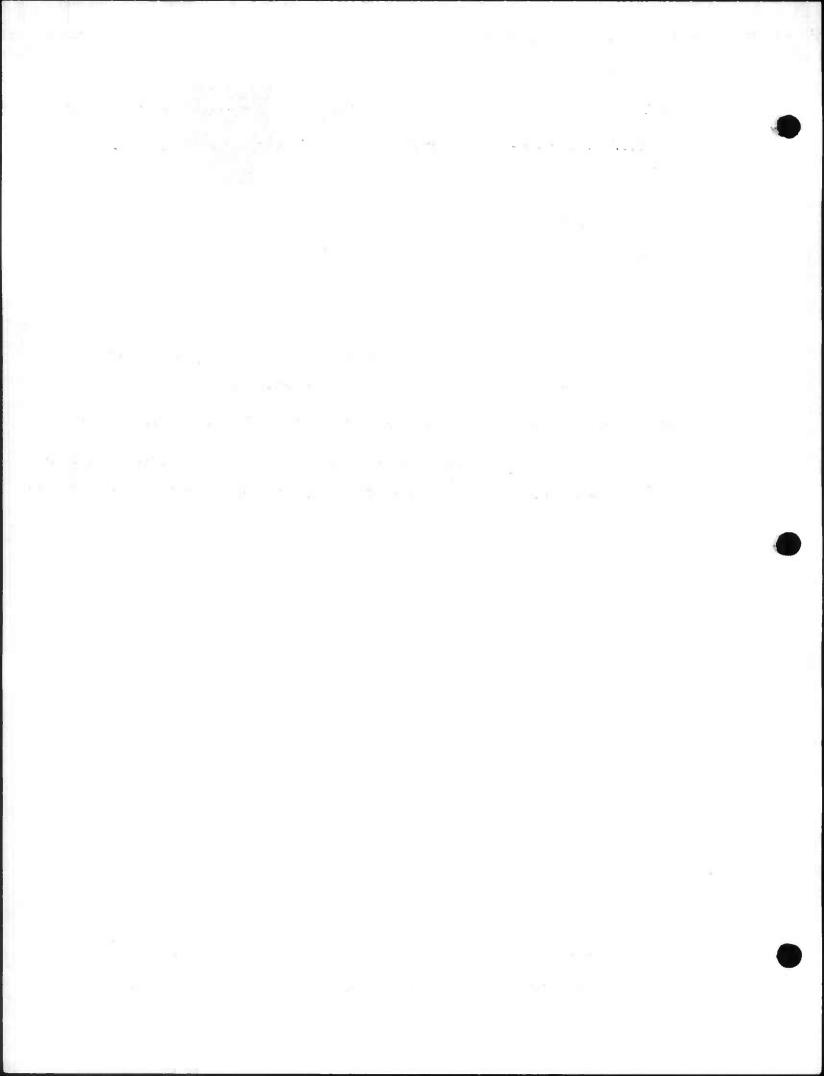
2M4 LABOS MO 31. Dete liled (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

UBUSE

							Cer	tificat	e of I	Death			Reg. No.	_	, ,	0003	V
			1. Decedent's Neme (First, Mi	ddle, Last)							[2. Dete of De			2016	3. Time of Death	1
	Physic		Wilsie		M				Park	ker		Month Februa	Dey 2 Y	4. 19	'ear 997	8:00 a.	m .
بار	/Medi Examii		4a. Facility Nama (If not institu	tion, give street a	nd number,)			4	b. City, To		ation of Deeth	-	County of		0.00 4.	
	E Aum		Salisbury Cer	ter. Cer	nesis	Elderca	re			Salish	ערווכ	MD	W	icom	ico		
	Funeral		5. Social Security Number	6. Sex		ga (In yrs. last bi		If Under	1 Year	If Undar 2	24 Hrs.	8. Date of Birt	th			ace (State or Fore	ign
	Director		213-22-7374	1 □ M 25	ŖF	69	Yrs.	Months	Deys	Hours	Min.	UG. Pa	1927		Count	ace (State or Fore (ry) MD.	
-			Usuei Residence of Decedent														_
	M M		10a. Stete 10b. Cour	nty		10c. City, Tow	n or Loc	cation							10	d. Inside City Lim	ts
	M AM	to	MD. WI	COMICO		SAI	ISB	URY								1 □ Yas 2 1	io
	with the Maryland a or 28s-f show Lbs notified at	Director	10e. Street and Number					10f. Zip	Code				10g. Citiz	zan of Wh	et Count	iry?	
	M Sa M	0	2001 AUTUMN G	ROVE COU	RT			1 2	2180	4				U.	S.A.		
	after death with the Marylar or itsms 23a or 28a-f show strings must be notified at	Funeral	11. Marital Status	12. Was	s Decedent	Evar In U,S.	13. V	Ves Deced	dent of H	ispenic Orig	gin? (Spec	cify Yas or No licen, etc.)	- 1	14. Race -			
2	of the right	E	1 ☐ Never Merried 2 ☑ M	lerried 1 🗆	ed Forces'						, Puerto H	ticen, etc.)			Whita, a		
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2	72 ho natur	Pe	15. Deced	ent's Education		16e	. Deced	ent's Usue	Occup	ation			16b. Kir	nd of Busin	ness/ind	ustry	
7	Media 7	Completed	(Specify only hig Elementery/Secondery (0-12	hest grade compl	a <i>ted)</i> ege (1-4or	5.1)	(Give I life. D	kind of wo OO NOT u	rk done d se retired	during most f)	of workin	g					
-	The state of the s	E	1.2	.) (011	ege (1-401	34)	BU	S CO	NTRA	CTOR			PUE	BLIC	SCHC	OOLS	
2	Hygi other ant, I	0	17. Fether's Neme (First, Midd	le, Last)						18. Mothe	r's Name	(First, Middle,	Meiden	Sumeme)			
maryland 21213-0020	lid be feminal freed ic eve	To B	ELMER	MATTHEWS						VIR	GIE	E HALES					
-	d 2 should th and Mer 7 is merks traumetic	-	19e. informent's Neme/Reletion		nt)	198	. Mellin	g Address	(Street	end Numbe	nd Number or Rural Route Number, City or Town, Stete, Zip Code)						
É	nit. Pages 1 an ariment of Heal ortant: If Item 2 injury or other 8.		JACOB PARKER-	HUSBAND			2001 AUTUMN GROVE COURT, SAL										
5			20e. Method of Disposition	HOODIND		20b. Place of Disposition (Name of cematery, cremetory or other place)						Dete		cation - Ci			
2			1 ☑ Burlal 2 ☐ Cremetic		from State		•	•				107/07					
i			4 Donetion 5 Other		0	WICOM						/27/97	SAI	-12BO	KI, P	MARYLAND 21804	
permit. Pages 1 ar Department of Hea important: if item: any injury or othe		21. Signature of Funarel Sarvi	ce Licensea		0				ss of Fecility		705 E	MATN	т Ст	SAT	LISBURY,	m.	
	Page 9		Quald	(//0)	un	ex	BOL	פעאונ	FUNE	KAL D	OME.	/UJ E.	LIMIT	A DI.	, on	JIDDUKI ,	
			23a, Part 1. Enter the disease, shock, or heart feilure. L	or complications	thet ceuse	d tha daath. Do	not ente	er the mod	e of dyin	g, such es	cerdiac or	respiretory e	rrest,			Approximeta Intervai Between	
ij	Physician														1	Onset and Deeth	
F	/Medical	Ш	Immediate Cause (Finei disease or condition	Δ	4. 10	-50. V	e Unes, UTIUS Premouras consequence of): ge Demen TA							3 DAG	13		
	Examiner		resulting in death)	Θ. //	ans	Due to (or es e	conseq	uence of):		1		- /				(1-
		Je.		6	210	SAD	5.	. (Don	10-17	DA				- 1		
	carificata be executed ding physician end isa es the burial-transit	Examiner	Sequentially list conditions	b	141	Due to (or es a						-		_			_
ć	an er		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury														
00/00	ta be	Medical	met minateo events	C		Due to (or es e	consequ	uence of):							-		_
	iffica g ph	Pe	resulting in deeth) Lest				,	,							1		
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2	that the death of the death of the detached for un	Physician	Pert ii. Other significant cond	Hone contribution	a to doath h	out not reculting t	n the un	deriving o	ouee civ	an in Part I		23h Did	tobacco	use contr	ibude to	the cause of dear	th 2
)	the de by the stached	hys		-						/	2						
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2	lew requires as been sign 2 should be	d by	0		(24e. Wes	en euton	ev :	24b. We	re eutopsy finding	6
2	v require been si should I	ete										perfo	rmed?	,	sva	Illable prior to	
necolds,	has t	Completed												,	of c	leath?	
	Page at a	Co										10	Yes 2	No	1 🗆	Yes 2 Hio	
AICOL	ician: The certificata rector, pag	Be	25. Wes case referred to medi exeminer?								of Deeth	(Check only o	one)				
5	Z 00 D	2	1 Yes 2 No	Hospitel:	1 🗆 inpati	ent 2 ER/O	utpetient	-		4 LI NU	rsing Hom	e 5 ☐ Resid	dence 6	3 □Other	(Specify)	
		ü	27. Menner of Deeth 1. Maturel 5 □ Pen		Dete of Inju	ury 28b.	Time of injury	2	Bc. Injun Work	y at k?	2	8d. Describe	how Injur	y occurred	i		
DISION	Attending ir daeth. ector: Attai by the fune	Certification:	2 ☐ Accident inve	stigation		500		M		Yes 2 □ i	No						
2	or Attendant after daet Director:	tific	3 ☐ Sulcida 6 ☐ Cou	id not be rmined 28e.	Plece of in	jury - At home, fa	arm, stre	et, factory	, office		2	8f. Location (or Rurai	Routa Number,	
5	s aftar	Ser.			wanuniy, e	ic. (Opecity)						Only or 101	, 51010,	,			
	To the Hospital within 24 hours a To the Funeral C completely filled											end menn	ner es st	eted.			
	P Fu	edicai	(Check only 2 Medic	al Exeminer: On	the basis of menner st	of exeminetion en	id/or Inv	estigetion	in my o	pinlon, deet	h occurre	d et the time,	dete end	plece, and	d due to	the ceuse(s)	
	Within To the	Me	29b. Signetura end titla of cert	fiar				290	. License	e number		T	29d. Dat	a signed (Month, L	Day, Year)	
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1	1 -		On Name and 11		UX		-		/_>	101	7		2	10	*/		
	φ		30. Neme end address of person	on who completed	ceuse of o	_											
	\		21 Date liter literation	1 Mins	20.2	11	04	Healt	hway	y Dr.	, Sal	isbury	, MD	211	804		-
	Sta		FEB 2 6 19	77 6.1.	JE Hegist	rer's Signature											
	Regist	ar	FED 26 13:	II Justa			90)										



State of Maryland / Department of Health and Mental Hygiene

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						Cer	tificate o	f Death			Reg. No.	- '	00000	
			1. Decedent's Nama (First, Middle, La	est)							2. Date of Death Month Day		3. Tima of Death	
Physici /Medic			I DAVIO ACCILIDATO PETERSON							Month Day March 6		997	1:15AM	
	Exami		4a. Facility Nema (If not Institution, give street and number)				4b. City, Town, or L			cation of Dee				
			Genesis Elder	Genesis ElderCare - Th			e Pines			2	πэ	lbot		
	Funeral		5. Social Security Number 6. 5		(In yrs. lest birthday) If Undar 1 Yaer If Under 24 Hrs			24 Hrs.				Birthplace (State or Foreign Country)		
	Director		129-07-1377	1ÅM 2□F	85 Yrs. Months Deg			s Hours	Min.	Jan. 1	5,1912	New	itry) York	
	filed within 72 hours after death with the Maryland Hygiene. Ther than "natural", or ferma 23a or 28a-f show ont, tre Medical Examiner must be notified at	tor	Usual Residence of Dacedant							04 1	3,2722	11011	LOZIK	
			10a. Stata 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits	
			Maryland Caroline Federalsburg								1 ☐ Yes 2 No			
		Director	10e. Street end Number		10f. Zip Coda					10g. Citizan of	What Cour	ntry?		
		<u></u>	3730 Bradley Road		21632					USA	USA			
		Funeral	11. Maritel Status	t Evar in U,S.	Evar in U,S. 13. Wes Decedant of Hi			Igin? (Spe	ecify Yes or N					
Baltimore, Maryland 21215-0020		F	1 ☐ Nevar Merried 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 🖾 No			If Yes, specify Cuban, Maxican, Puèrto 1 ☐ Yas 2 ZÃNo Specify:			Rican, etc.)	Bla	Black, White, atc. Specify: White		
		by	3 Widowed 4 Divorced	If Yas, Giva Yeer or Detes	Yeer or Detes:						Specil			
		ted	15. Decedant's E	ducation		16a. Deced	ant's Usual Occ	s Usual Occupation			16b. Kind of B	16b. Kind of Businass/Industry		
		-	(Specify only highast grada completed) Elamentery/Secondary (0-12) Collega (1-4or		B (1-40r5+)		sind of work dona during most of work O NOT use retired)			ng	Home Building			
							Carpenter						ng	
			17. Fathar's Nama (First, Middle, Last)				18. Moth	ar's Nama	(First, Middl	a, Maidan Sumai	na)		
	2 should be and Menta is marked aumatic er		Hjmalar Irving Pe					Anne Rapson						
			19a. Informant's Name/Ralationship (Type, Print)		19b. Mallin	g Addrass (Stre	et and Numb	er or Rura	I Route Num	ber, City or Town	, Stata, Zip	Code)	
			Mary Ann Peterson	/Wife									nd 21632	
	is 1 and 2 if Health item 27 i		20a. Mathod of Disposition			a of Dispo	sition (Name of		.,	Data	20c. Location			
	0 - =		1 Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Othar (Special				of Good		se1 3	1/8/97	Secreta	rv M	arvland	
	permit. Pag Department Important: any Injury o		21. Signature of Juneral Service Lice		27				- 1		1	-		
			Zeiler Funeral Home, 106 Main Street,											
_		1	P. O. Box 207, East New Market, MD 21631 Sa. Part. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate											
	Physician /Medical Examiner	-	25a. Part1. Enter the disease, or con- shock, or heart failure. List only	plications that cause one cause on each	ad the death. line.	Do not ente	er the mode of d	tring, such as	cardiac o	or respiratory	arrest,		Approximate Interval Between	
		Examiner								Onset and Death				
r			disease or condition							Weeks				
90,			resulting in death) Dues to (or as a portequence) of: Preumpur Per Per Per Per Per Per Per P							0				
			_	COOP	1) wi	the	(leu	Men		neu	mruc	P	Tun	
		cam	Sequentially list conditions. Due to (or as a consequence of):											
	icate be execu physician and s the burial-tra		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
68760,	ertificate be fing physicis is as the bur	edical												
9 x	ding p	Mec												
Bô	requires that the death or been signed by the attend should be detached for us			0										
o.		sic	Part II. Other significant conditions of	ontributing to death	but not resulti	ng in the un	derlying cause,	given in Part	L	23b. Dic	d tobacco use co	ontribute to	the cause of death?	
Records, P.C		Physician	Hyperbusive Cardiowascular Dis with CHF						E	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow				
		by							1					
			180000								s an autopey formed?	800	ere autopsy findings allable prior to	
ŏ		ple								1	TOTAL CONTRACTOR OF THE PARTY O	00	mpletion of cause death?	
Division of Vital	40 A. P.	e Completed								30	Yes 20M6	15]Yes 2□No	
			25. Was case referred to medical					Off Disc.	a of Please	(Check only			2100 20110	
	20 80	o Be	examiner?	Hospital:	ing offer	Mark to the second	art nos (Wher /		- American Company	STATE OF THE PARTY			
		1: 10	27. Manny of Death	1 ☐ Inpat 28a. Date of Inj	A Particular Committee Com	VOutpatien 8b. Time of	28c. In				idence 6 D0s how injury occur		()	
	Attending is death.	Certification:	1 DNatural 5 Pending (Month, Day Year) Injury Work?											
	death death ctor: /	loa	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury - At home				1001				(Stead and Num	har or Bure	d Doute Number	
	To the Hospital or Attent within 24 hours after deal To the Funeral Director: completely filled in by the	T .	4 ☐ Homicide determined	building, e	Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						 Location (Street and Number or Rural Route Number, City or Town, State) 			
		100	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
	Hop 24 h Fun Fun	edical	29a. Certifler (Check only and in the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To the Within To the compl	M	29b. Signature and title of certifier \ \ \ \ \ 29c. License number 29d. Date signed (Mgnth, Day, Year)											
	F 3 F 8	1	1010/1111 HORAL DORTIS 21/107											
,			7/0/7											
		1	30. Name and address of person who completed causa of daath (Ham 25a) (Type-Print) WILLIAM IX NOOC TY MD CASION Nd 2160 /											
			31. Data filed (Month, Day, Year)	NO OCY	U /	1117	,	1	/1/	1	170	a	.00 /	
	Sta Registr		MAR -7 19		trar's Signatur	Rand-11				,				
	negisti	aı	mm1/ ~ 1 13.	II TOTAL	and makes ,	-								

State of Maryland / Department of Health and Mental Hygiene

				State of Maryla		rtificate c			eg. No.	7 0	8037
1	Physic		Decedent's Nema (First, Middla, Las ALLEN FRA	NKLIN	0	illen		2. Data of Deat Month February		Voor	3. Time of Death
я	/Medi		4a. Facility Neme (If not Institution, give		Ųΰ	illien	4b. City, Town, or I	-	4c. County		
1	Examiı	ier	8804 Archid Dri				Delmar		Wico		
	Funeral Director		5. Social Security Number 6. So 230-05-4411		. last birthdey) Yrs.	If Undar 1 Ya Months De	ar If Under 24 Hrs.	8. Data of Birth (Month, Day, July 11,	Year)		e (Stata or Foreign
	and and		Usual Residence of Dacedant 10e. Stete 10b. County	10c. C	ity, Town or Lo	cation				104	inside City Limits
	Maryt e-f sho lifed a	tor	Maryland Wicom		Delmar						1 Ves 2 No
	fer death with the Maryland fleers 23e or 25e-f show free must be notified at	al Director	10e. Street end Number 8804 Archid Driv	'e		10f. Zip Cod 218		1	0g. Citizan of W USA	/hat Country?	
020	72 hours after dou "natural", or flems adical Examiner m	by Funeral	11. Marital Status 1 □ Never Married 2 □ Merried 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever In Armed Forcas? 1 1 Yas 2 No If Yes, Give Yeer or Detes: 1,1,1,1		Was Decedent of t Yes, specify C 1 ☐ Yas 2 🔯 N	of Hispenic Origin? (Suben, Maxican, Puart lo Specify:	pecify Yes or No- o Rican, atc.)		- Amarican I k, Whita, atc.	
ĕ		9	15. Decedent's Ed	ucation	16a Deced	dant's Usual Oc	cupation		16b. Kind of Bu		
Maryland 21215-0020	within 72 ene. Than "nat	Completed	(Specify only highast grade	de complated) College (1-4or 5+)	(Giva	kind of work do DO NOT use ret	na during most of wor ired)	king			
12	her in	ပိ	1 I 17. Father's Nema (First, Middla, Last)	_	рера	rtment		na (First, Middle, M		of Na	avy
lan	Mental Parkad of	To Be		Quillen			Julia		Colona	θ)	
lary	2 should and Men a marks surradio	-	19a, Intormant's Name/Relationship (7	ype, Print)	19b. Mallin	ng Addrass (Stre	eet and Number or Ru	ıral Routa Number	, City or Town,	Stata, Zip Co	de)
	and 2 n 27 h		Brad S. Quillen/s		419	6 Main	St.,_Chino	coteague,	VA 233	336	
Baltimore,	Pages 1 nent of Hu nt: If Nen nry or oth		20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐		Plece of Dispo cematary, cran	sitlon (Name of natory or other)	olace)		20c. Location -		Stete
Ħ	tment tant: I (lury o		4 □ Conation 5 □ Other (Specify	S		1 Memory	Gardens	2/26/97	Hebron,	MD	
Bal	Depart Impor any in		21. Signature of Furieral Service Licens	A. Camos	103.	Hollow	dress of Facility ay Funeral ow Hill Ro		burv. N	1D 2180	04
	is.		23a. Part1. Enter the disaesa, or comp shock, or heart tailure. List only of	elications thet caused the das ona causa on aach line	ith. Do not ente	er the mode of	tylng, such as cardied	or respiratory arre	est,	Ap	proximate erval Between
	Physician /Medical Examiner		Immediata Ceusa (Final disaasa or condition resulting in death)	a. Corcles Dua to	u Cir	rest					NIN)
		er		Dua to	or es a conseq	quance ot):		111.10			YRS
	outed ansit	Examiner	Sequentially list conditions		or as a conseq		:unlu	Lilley	u		1163
, 0,	e exe		Sequantially list conditions, if eny, leading to immediate ceusa. Entar Underlying Causa (Diseasa or injury that initiated avants								
68760,	tificate be executed g physician and es the buriel-transit	edical	that initiated avants resulting in death) Lest	Due to (or as e conseq	uance of):			·		
	n certifi anding use es			d							
Вох	seath cert ettending	clar	Doe II Other else Misest conditions on	madificulting to decide but a star	- Int - I - An - I		afras la march	on Pida			
P.O.	ires that the death cer signed by the ettendin d be detached for use	Physiclan/M	Pert II. Other significant conditions co		suiting in the ui	nderrying ceusa	given in Part I.				e cause of death? ly 4 Unknown
		by F	Siapete M	ucuis							
of Vital Records,	sw requisite special s	Completed						24a. Wes a perform	n autopsy ned?	availat	autopsy findings ble prior to etion of causa th?
E	는 물을	Co						1 □ Ya	as 2 No	1 □ Ye	es 2 No
<u> </u>	Physician: The ribis certificate rail director, peg	Be c	25. Wes cesa ratarred to medical axaminer?	Hospital:	-		Other	ath (Check only on			
	F 00 T	tlon: To	27. Mannar of Deeth 1 Natural 5 Panding	28a. Data of Injury (Month, Day Year)	28b. Tima ot Injury	28c. Ir	yorkan 4 □ Nursing H	oma 5 ⊟ fasida 28d. Dascribe ho			
Division	after death. Director: After	Certification:	2 Accidant Invastigation 3 Suicida 6 Could not be 4 Homicida datamined	28a. Place of injury - At I building, atc. (Spec	noma, farm, str		- 121	28t. Location (St City or Town	reet and Number, Stata)	er or Rural Ro	oute Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical Ce	29a. Certifiar 1 Certifying Phy (Check only one)	sician: To the bast of my kn	owladga, daath ation and/or Inv	occurred at the	tima, data and place y oplnion, death occu	, and due to the ce	ause(s) end ma ata and place, s	nnar es state	d. cause(s)
	o the ithin o the omple	Mec	29b, Signetura end titla of certitiar	end menner steted.		29c. Lies	ansa number	2	9d. Dete signed	(Month Day	, Year)
	F ₹ F 8		× Lucid	In lum in		-	10655		2/2.	10-	
	\ A		30. Nama and addrass of person who c	11	m 23a) (Type.				4/24	7/	
50	NA		DUNALD M. W.	UD, MD PR	nc						
	Sta Registr		31. Data filed (Month, Day, Year) FEB 26 1997	32. Registrar's Sign	Rardall						

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

08038

							0.	or unicate c	ח טפני	aur		Reg. No.		0000
	Physic /Medi		1. Decedant's Nam	w w	MARILL	R	ohvk	rugh			2. Data of Da Month FEBRUA	Day Day	Year 1997	3. Time of Death 12:50 PM
7	Exami		4a. Facility Nama (If not institution,	giva street and nu	m <i>ber</i>))	4b. Cit	ty, Town, or L	ocation of Dea	th 4c. County	of Deeth	
			SHADY G	ROVE ADV	ENTIST H	IOSPI'	TAL		RO	CKVILI		MONTG	OMER:	Y
	Funeral		5. Social Security		Sax		n yrs. last birthda	y) If Undar 1 Ya Months Da		Indar 24 Hrs.	8. Date of Bi	rth ay, Year) 6, 1947	9. Birth	place (Stata or Foreign ntry) RYLAND
	Director		216-50-89		1 X M 2 □ F	49	Yrs.	WOTHING DE	, ,	111111	JULY 1	6, 1947	MA	RYLAND
	p .	1	Usual Rasidanca o	10b. County		140	la City Town as	anatine .						
	arysa d at	_			OMEDN.		C. City, Town or							10d. Inside City Limits
	A Fil	cto	MD	MONTGO	JMEKI		ROCKVILI	ır.						1 X Yas 2 No
	after death with the Maryla or Nerre 23a or 28a-f show smither must be notified at	Funeral Director	10e. Street end Nu					10f. Zip Cod				10g. Citizen of \	What Cou	intry?
	23a	<u>e</u>	755 AZA	LIA DRIV	VE			20	0850			USA		
	de de	ine	11. Marital Stetus		12. Wes Dec Armed Fo		r In U,S. 13	. Was Decedant of It Yes, specify C	of Hispan	ic Origin? (Sp	pecify Yas or N	0- 14. Red	e - Ameri ck, White	can Indien,
0	a a a		1 Nevar Marr	ried 2 Merrie		va □NoV	TET-	1 ☐ Yes 2 🕅 1			r riouri, ara.,			
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ñ	Dep Per		10	1/1/	1. +							BOX 24		
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1	/Medical Examiner		Immediata Causa diseese or condition	on	Α	SLA	DDER	CAN	cer				19	4 YEARS
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Vital	Physician: The lithis certificate heral director, page	Be	25. Wes casa rafar exeminar?		Hospital:	/			-	Placa of Dea	th (Chack only	ona)		
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	is af	Ce												
	t hour	edical	29e. Cartifiar (Check only	1 Certifying	Physician: To the miner: On the b	best of my	y knowledge, dea	th occurred at the	a time, de	te and plece,	and due to the	ceuse(s) end me	ennar as s	steted.
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in		one)		and men	nar stated					rou at tird tillia	cata and place,	end due l	o are cease(s)
	To To 1	Σ	29b. Signature and	title of certifiar	1 .1	-	1		en <i>s</i> e num			29d. Dete signe	d (Month,	Dey, Year)
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			State of Maryla		tificate of		Re	g. No.	17 08039
Physic /Med		Decedent's Neme (First, Middle, Las REGINALD	GARDNER		RUARK		2. Dete of Deeth Month	24 g	Yeer 3. Time of Death
Exam	iner	4a. Facility Name (If not institution, give 413 Light Street	street and number)			4b. City, Town, or Loc Cambride		4c. County of	of beath nester
Funera Directo		5. Sociei Security Number 6. Se	ex	rs. last birthdey) Yrs.	If Under 1 Yeer Months Deys		8. Dete of Birth (Month, Dey, July 25,1	Year)	Birthplece (State or Foreign Country) Maryland
yland		10a, Stete 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
Sarf s	Director	Maryland Wicomi	LCO	Cambr					1 √ Yes 2 No
with the or 2	Ö	10e. Street end Number 413 LIght Street			10f. Zip Code	1613	10	g. Citizen of W USA	het Country?
within 72 hours after deeth with the Maryland liene. than "natural", or Heme 23a or 28a-f show the Medical Examinat must be notified at	by Funeral	11. Meritei Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever In Armed Forces? 1 ⊠ Yes 2 □ No If Yes. Give	11	Ves Decedent of H	dispenic Origin? (Spe an, Mexican, Puerto F	city Yes or No- Rican, etc.)	14. Rece	- American Indien, c, White, etc.
within 72 hou one. Than "natural	Completed t	15. Decedent's Ed (Specify only highest grad Elementery/Secondary (0-12)	ucation	16e. Deced (Give iife. L		pation during most of workin d)	ng	6b. Kind of Bus	sinass/industry
T1 Co. L. Sec.		17. Fether's Neme (First, Middle, Last)	_	Cou	rier	16. Mother's Neme		Phone Cleiden Sumeme	A 3
should be Ind Mentel I marked of	To Be	Wilby Ruar	ck			Lula	Mi	11s	
OI 00 97 E	1	19a. Informant's Name/Relationship (7	ype, Print)			and Number or Rura			
Pages 1 and 3 sent of Health int: If Nem 27 iny or other tra		Steve Ruark/son 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specify	Removal from State	o. Pieca of Dispos cemetery, crem			Dete 2	0c. Location - 0	04 City or Town, State Maryland
permit. Pages 1 ar Cepartment of Hea Important: if Nem 3 any injury or other		21 Signature of Funeral Service Licens		1031		ess of Fecility By Funeral How Hill Rd.,		. MD 218	0/4
death certificate be executed Was a strending physician and and cruse as the buriel-transit	edicai Examiner	23a. Part1. Entar the disease, or comb shook, or heert failure. List only of the combined shook, or heert failure. List only of the combined shook, or heert failure. List only of the combined shook	b. Aper Due to	o (or es e consequence o (or es e consequence o consequenc	uence of):	mus			onset end Deeth f min Stro
es that the digned by the	ed by Physician/M	Part II. Other eignificant conditions co	ntributing to death but not r	esulting in the un	derlying cause giv	ven in Pert I.	24e. Wes en	eutopsy	tribute to the cause of death? 3 Probably 4 Unknow 24b. Were autopsy findings
has b	Completed						performe		aveileble prior to completion of cause of death?
ysician: The	BeC	25. Wes case referred to medical examinar?				26. Placa of Death			
ling Phys h. After this funeral di	2	27. Manner of Deeth 15. Matural 5 Pending 2 Accident Investigation	Hospitel: 1 inpatient 2 26e. Dete of injury (Month, Dey Year)	26b. Time of Injury	28c. Injui	y et 2 No	ne 5 Residen 26d. Describe how		
5 4 5 5	Certification:	3 Sulcide 6 Could not be 4 Homicida determined	26e. Plece of Injury - At building, etc. (Spe		eet, fectory, office	2	26f. Location (Stre City or Town,	eet and Numbe Stete)	or or Rurel Route Number,
24 hours Punersi etely filled	edicai	29e. Certifiar (Check only one)	sician: To the best of my k inar: On the basis of exemi end menner steted.	nowledge, deeth netion end/or inv	occurred at the tire astigation, in my o	ma, data and piece, e pinion, daeth occurre	nd due to the cau ed at the time, dat	use(s) end man te end piece, a	nar as stated. nd due to the ceuse(s)
To the Hospital To the Funeral I Completely filled	Me	29b. Signeture and title of certifier	Allen 15		29c. Licens	6388	29	d. Dete signed	(Month, Day, Year)
+IVA		30. Neme and address of person who o	ompleted cause of deeth (It	tem 23a) (Type, F	_ /	Ens Hu	nlock	Ma	2/693
St Regis	ate trar	31. Date fied (Month, Day, Year) FFR 2 1887	House and Subject of S	or Kardall					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

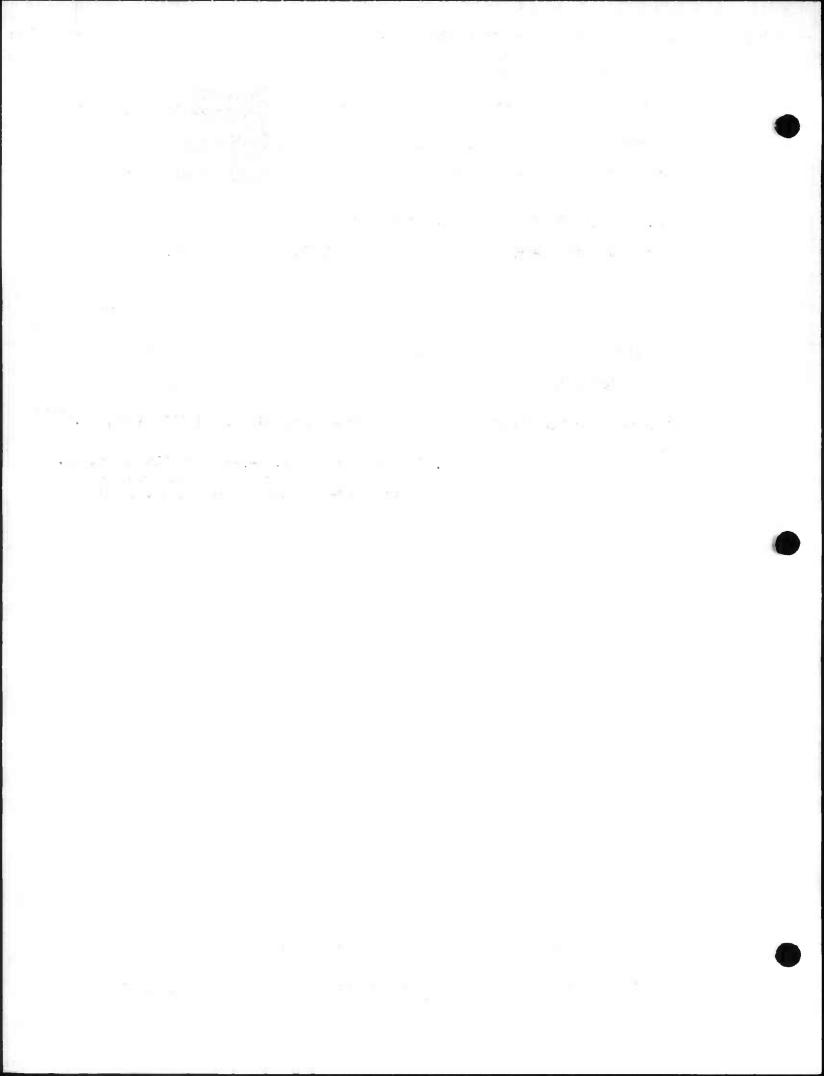
State of Maryland / Department of Health and Mental Hygiene

				State of Mai		ertificat				giene g Reg. No.	17 08	8040
	Physic /Medi		1. Decedant's Name (First, Middla, La MARY	st) WRI	GHT		Ro	unds	2. Data of De Month,	Dey 0	Year	Tima of Death
	Examil Funeral Director		5. Sociel Security Number 6. 5	1 Medical	Center (In yrs. last birthday 79 Yrs.		<	City, Town, or L CALLS but If Undar 24 Hrs. Hours Min.	ocation of Deeth	4c. County UC.	anico	(Stata or Foreign
	aryland show		Usual Rasidence of Decedent 10a. Stata 10b. County	1	10c. City, Town or L	.ocation						nside City Limits
	the Maryla 28a-f shor	Director	MARYLAND WICOMI	CO	SALISBU		/	1.			1	Yas 2 No
	death with the Maryland ms 23a or 28a-f show r.msst.be notified at	N Dir	10e. Street and Number 29970 DIXON ROAD			10f. Zip		4		10g. Citizen of	•	
020	or ha	by Funeral	11. Meritel Stetus 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forcas? 1 Tyas 2 No If Yes, Giva Yaar or Datas:	rer in U,S. 13.			spanic Origin? (Sp., Maxican, Puerto	pecify Yas or No Dican, etc.)	- 14. Rai Bla Specif	ce - Amarican Inck, White, etc.	
Maryland 21215-0020	c .	Completed	15. Decedant's Ec (Specify only highest gra Elamantary/Secondary (0-12) 12	ducation de complated) College (1-4or 5+)) life.	edant's Usua a <i>kind of wor</i> DO NOT us	a ratired)		king		usiness/Industry	,
land 2	a filed other	To Be Co	17. Fathar's Nema (First, Middla, Last, WALTER WRIGHT	5	NSOL	JIMNI		18. Mother's Nam			GOVERNI ma)	TEN I
Mary	nd 2 should be lith and Ments X7 is marked r trsumatic sy	-	19a. Informant's Name/Relationship (CLAUDIA WHITELOC	***			(Street a	nd Number or Rui	ral Route Numbe			9)
Baltimore,	0 1 1 5 0 1 1 5		20a. Mathod of Disposition Burial 2 Cramation 3 Donetion 5 Other (Specific	Ramoval from State	20b. Place of Disp cemetary, cre	osition (Nan emetory or o	ne of thar place	»)	Data	20c. Location	- City or Town, S	
Baltir	permit. Pa Department Important: any injury office.		21. Signature of Funeral Service Light		BEECHWOO H			s of Facility RAL HOME		PRINCES	S ANNE,	MD.
Box 68760,	State of the property of the p	VMedical Examiner	23a Part1. Enter the disease, or com shock, or heart tailura. List only immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CEREPS DE DE ATTELO SCU	VASCULAS	equence of):	CIT	ENT			Onse	roximata rval Between et and Death
	the atter	Physician/M	Part II. Other algnificant conditions o	ontributing to death but	not resulting in tha	undarlying co	ausa giva	n in Part I.	23b. Dld	tobacco vas co	entributs to the	cause of death?
s, P.O.	that the ded by detac	by Phy	MITRAL VALVE	DYS FUNCTI	on/ Disc	ASÉ			10	Y88 2□ No	3 Probably	4)R[Unknown
Records,	s law requir has been s ps 2 should	Completed	CORONARY ARA	ELY DISE	45E				24a. Was perio	an autopsy rmed?	avellable	utopsy findings e prior to tion of cause 17
Ita	foian: The la certificate ha nector, page	Be Co	25. Was casa rafarred to medical					26. Placa of Deal	th (Check only o	-	1 🗆 Yes	2 No
ion of Vital	ding Phys h. After this funeral di	2	axaminar? 1	Hospitel: 1 Unpatient 28a. Data of Injury (Month, Day Y	28b. Time		8c. Injury Work	4 LI Nursing Ho	oma 5 Rasio 28d. Describe I			
Division	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely tilled in by the f	Certification:	3 Sulcide 6 Could not be determined	28a. Place of Injury building, atc. (/ - At homa, farm, s (Specify)	treet, factory	, office		28f. Location (8 City or Tox		ber or Rural Rou	ita Number,
	To the Hospital or within 24 hours affice To the Funeral Director completely filled in	edical	29a. Certifiar (Check only one) Certifying Ph	ysician: To the best of rainer: On the basis of a and menner stete	xamination end/or in	th occurred envastigation,	et tha time in my op	a, data and place, inion, daath occur	and dua to the red at tha tima,	cause(s) end m data and placa,	ennar as stated. end due to tha c	cause(s)
	To the To the comp	Ň	29b. Signature end titla of certifier	. 0 (29c	. License	number			ed (Month, Dey,	Year)
			30. Nama and addrass of person who	C- Usbu	th (Itam 23a) (Type	Dalasi	45			-	3/97	
			Nicholas Oburn	201	PINE 3	laff	Rd.	Salis	bury, M	rd , 218	101	
	Sta Registr		31. Data filed (Month, Dey, Year)	32. Ragiovar's	s Signatura				/			

State of Maryland / Department of Health and Mental Hygiene

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						C	ertificat	e of	Death			Reg. No.	21	00041
			1. Decedent's Nama (First, Middle,	Last)							2. Data of D		Veer	3. Tima of Death
	Physic /Medi		Hattie	GALE				Smit	h		Month Februa	ry 25, 1	Year 1997	7:08 AM
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	Funeral			3. Sax	7. Age (In yr	s. last birthde	Months	1 Yeer Days			8. Dete of B (Month, D		9. Birth	place (State or Foreign
	Director		219-07-5108	1□ M 2√F	9.	3 Yrs.	NOMIS	Days	nouis	IVIIII.	2 8	04	POLK	'S ROAD
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	aryta aho dat	2	72. 730	DOET		City, Town or		_						10d. Insida City Limits 1 ☐ Yes 2 🕅 No
	th the Maryland or 28a-f show e notified at	Director	MD. SOME	KSET		KINCE	SS ANN					an and the		
	nath with the Marylar ns 23s or 28s-f show must be notified at	ត់	16 PINE KNOLI	DRIVE			10f. Zip		1853			10g. Citizen of	What Cou	ntry?
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Maryland 21215-0020	2 she and and is ma	-	19e. Informent's Name/Ralationship	(Type, Print)								ber, City or Town		
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ore	Pages 1 a nent of His rut If Nam iry or othe		20a. Method of Disposition 1 XBuriai 2 ☐ Crametion 3	☐ Ramoval from		cematary, o	sposition (Na cramatory or c	ma of other plac	ce)		Data	20c. Location	- City or T	own, Stata
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Baltimore,	Department of mportant: If any Injury or ance.		21. Signature of Eunaral Service Lie	censee	100							EMORIAL		
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r	/Medical Examiner		Immediata Cause (Final disease or condition resulting in daath)	a	on	Ges 7	7 ve	Ke	NZ	(Zmli	ne		years
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œ.	that the death ad by the etter deteched for	Physician	Part II. Other significant conditions	contributing to de	eath but not re	asuiting in the	e underlyina a	ause div	an in Part	I.	23b. Dlo	tobacco use co	ontribute t	o the cause of death?
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ecc	N 88	pie	/											omplation of cause death?
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o V	5 00 0	2	1 ☐ Yas 2 No	Hospital: 1 🗆 I	npatiant 2	☐ ER/Outpet	tiant 3 DC	Oth Oth	ar: 4 N	ursing Ho	ma 5□Ras	sidance 6 🗆 Oti	nar (Speci	fy)
2	Affing Ph h. Affer th funeral	:0	27. Mannar of Death 1 ☑ Natural 5 ☐ Pending	28e. Data (Mont	of Injury th, Day Year)	28b. Time Injur	of 2	28c. Injur Wor	y at k?		28d. Describe	how injury occu	rred	
Sio	Attending or deeth.	cati	P Accident Investigate 3 Suicide 6 Could no	t he			М		Yas 2					
Division	5445	Certification:	4 Homicide determine	ed Zoa. Flace	of Injury - At ng, atc. (Spec	home, farm, cify)	streat, factor	y, office				(Street and Num. own, Stata)	ber or Run	al Routa Number,
	pital ours ours oral filled		29a. Certifiar 17 Certifying	Dhartalan Tan								4.		
	To the Hospital or Attend within 24 hours effer deatl To the Funeral Director: completely filled in by the	edicai	(Check only one)	Phyeician: To the aminer: On the be	best of my kr asis of axamir ar statad.	nati <i>on</i> end/or	invastigation	at the tin	ne, date an pinion, dea	ath occurr	and dua to the ed at the time	a ceusa(s) and m , deta and place,	and dua t	o tha ceuse(s)
	ithin o the	M	29b. Signetura and titla of certifier	910 111911	iai siaiau.		290	c. Licens	e number		- T	29d. Dete signe	ed (Month.	Day, Year)
	F 3 F 5		1 On i	11	10		4	0:	395	マノス		7/7	1	192
			30 Name and address of parent ::	o completed some	a of death (the	am 22a) /T	Drint)		110	11-3		<i></i>	- /	
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State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical **Examiner**

3. Tima of Death 1840 P

10d. Inside City Limits 1 ☐ Yas XX No

WHITE

Funeral Director

Directo Funeral P

Completed

the Maryland show r 25a-f show inotified at b the Medical Examiner must be Items 23a hours after ò "natural" Pan ould be fit.

If and Mental He permit. Pages 1 and 2 should I Department of Health and Men Important: If Item 27 is marker

altimore, Maryland 21215-0020

Physician /Medical Examiner

physician and s the burial-transit The law requires that the death certificate be executed Box 68760 62 P.O. I s been signed to should be dete Records, certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

Physician/Medicai

à

Be Completed

2

Certification:

Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Death Month CRAIG LEON SMITH MARCH 04 1997 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth MARYLAND RTE #05 & RTE#231 HUGHESVILLE CHARLES 5. Sociel Sacurity Number If Undar 1 Year | If Under 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 9. Birthpiaca (Stata or Foreign Months Deys Hours Yrs. 231-33-9164 26 FEB. 19, 1971 WASHINGTON DC Usual Rasidanca of Dacadant 10a. Stata 10b. County 10c. City, Town or Location MARYLAND **CHARLES** WALDORF 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 478 THISTLE PLACE 20601 UNITED STATES 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yes 2 1 No if Yas, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - Amarican Indien, Black, Whita, atc. 11. Maritei Status Navar Married 2 Married 1 ☐ Yes XXNo Specify: 3 ☐ Widowed 4 ☐ Divorced Specify 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 12 GROUNDS MAINTENANCE ENGINEER STATE OF MARYLAND 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) LEON P. SMITH DIANE BRIDGETT 19a. informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 6347 YATES FORD ROAD, MANASSAS, VIRGINIA 20111 LEON P. SMITH - FATHER 20a. Method of Disposition 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, State 1 X Bunal 2 □ Cramation 3 □ Ramovel from Stata 4 Donation 5 Other (Specify) TRINITY MEMORIAL GARDENS MARCH 8, 1997 WALDORF, MD MGB gnature Funaral Service Licangaa Shau BROHAWN THE HUNTT FUNERAL HOME, INC. MARK G. M00053 P.O.BOX 156, WALDORF, MARYLAND 20604 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediata Causa (Final HULTIPLE DYJUMES diseasa or condition rasulting in death) Dua to (or as a consequenca of) Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disease or injury that initiated avants rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of)

Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

26. Place of Death (Chack only one)

23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No

24a. Was an autopsy performed?

24b. Wara autopsy findings eveilabla prior to completion of causa of death?

Approximete Intarvai Batw Onsat and Death

1 Yas 2 No

25. Was casa rafarrad to medical axaminer? XXYas 2 No

> 5 Pending Investigation 6 Could not be datarmined

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 4 97 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

28b. Time of 18308 28c. Injury at Work? 1 Yas 2 No

Other: 4 Nursing Home 5 Rasidanca & Other (Specify) SCENE 28d. Rescribe how injury occurred WITH BLOTHERLISA DRIVER OF GAR THEOLISION

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) MOST 215 ALLEAN AGO MO

29a. Certifiar

27. Mannar of Death

1 Natural

2 Accident

3 Suicida

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mennar stated. 29b. Signatura and titia of cartifie

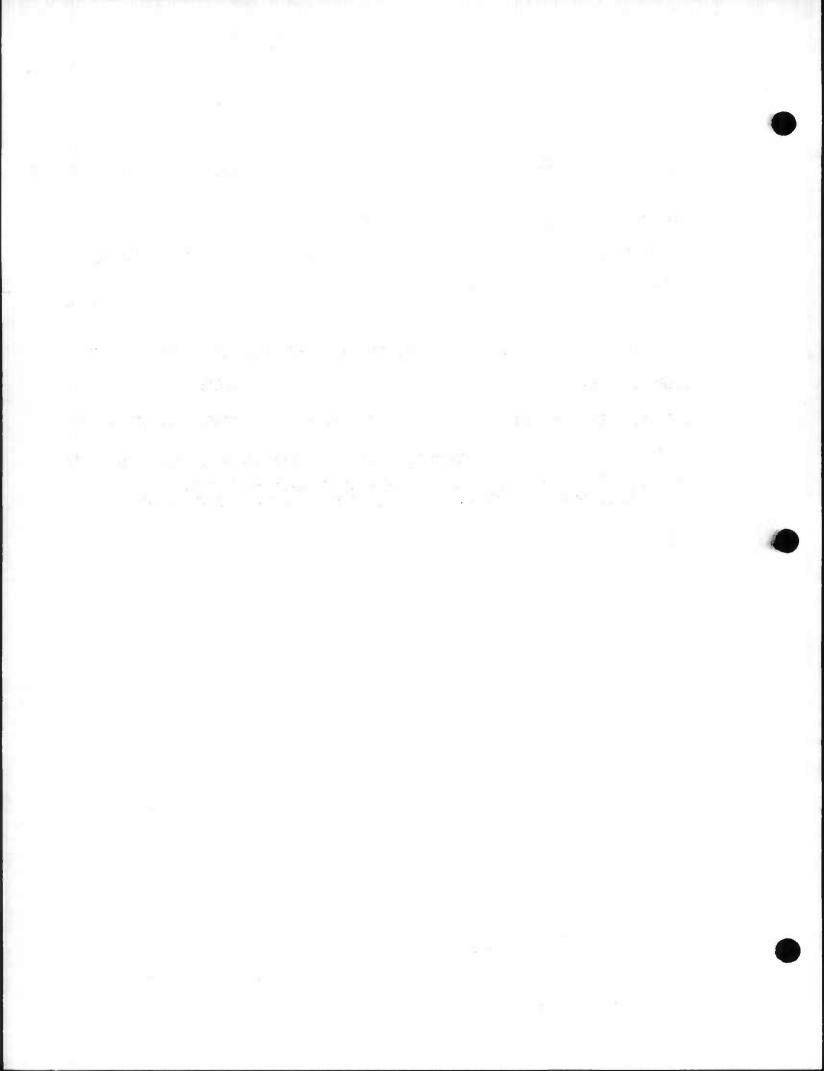
29c. Licansa number O.C.M.E 29d. Data signed (Month, Day, Year) MARCH 05, 1997

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

(ARYDONON

111 Penn Street, Baltimore, Maryland 21201

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month 5 STEVENSON. March 1, GRACE 1997 7:05 a.m. /Medical 4b. City, Town, or Location of Deeth 4a. Facility Neme (If not institution, giva street end number 4c. County of Death Examiner Meridian-Corsica Hills Nursing Center Centreville Queen Annes If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (fn yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 200 Yrs Director 232-03-3119 September 23, 1905 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director Queen Annes Maryland Stevensville. t0g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 8 must be 205 Bay Drive 21666 U.S.A. hems 23a 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Rece - American Indian, Bleck, White, etc. 11. Maritat Status the Medical Examiner 1 □ Never Married 2 □ Married 1 Yes 2 No If Yes, Give Year or Detes: 'natural', or Sattimore, Maryland 21215-0020 1 ☐ Yes 2 2 No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry during most of working Pages 1 and 2 should be tiled within 7 tent of Health and Mental Hyglens. Int. If them 27 is marked other than "1 Elementery/Secondery (0-12) Cotlege (1-4or 5+) 12 Nurse Medical 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Lawrence Robert Simpson Aureola Guthrie 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health a Important: If Nem 27 is any injury or other tras Thomas W.B. Stevenson III/Son 2936 4-H Park Road, Centreville, Maryland 21617 20e. Method of Disposition 20b. Place of Disposition (Name of cematery, cremetory or other place) 20c. Location - City or Town, Stete 1 Buriei 2 ☐ Cremetion 3 ☐ Removei from Stete Forest Lawn Gardens, March 3, 1997 McMurray, Pennsylvania 4 Donetion 5 Other (Specify) 21. Signature o Finerei Service Licensae Fellows, Helienbein & Newnam Funeral Home, P.A. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, or hearn eiture. List only one cause on each line. 130 Speer Road, Chestertown, Maryland 21620 Onsat and Death **Physician** /Medical MOS Immediate Cause (Final disaese or conditi-resulting In deeth) Examiner MELLETINS Examiner Sequentietly list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting In deeth) Last and DEMENT Box 68760. physicien Physician/Medicai the Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? Division of Vital Records, P.O. 1 Yas 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings avellebte prior to completion of causa of death? 24e. Wes an eutopsy performed? Completed 1 Yes No 2 1 NO 25. Wes case referred to medicel examiner? Be 26. Plece of Deeth (Check only one) Other: Sursing Homa 5 Rasidence 6 Othar (Specify) ၉ 1 Yes 2 No. 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of Certification: 5 Pending

To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certific

1 Z Naturet 2 Accident 3 Sulcide 4 ☐ Homicide

Investigation 6 Could not be

28e. Dete of Injury (Month, Dey Year) 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

281. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifian

Medical

5

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and dua to the cause(s) end menner as steted.

2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end manner stated.

29b. Signatura and titla of certifiar

31. Dete filed (Month, Dey, Year)

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- 4

29c. Licansa number

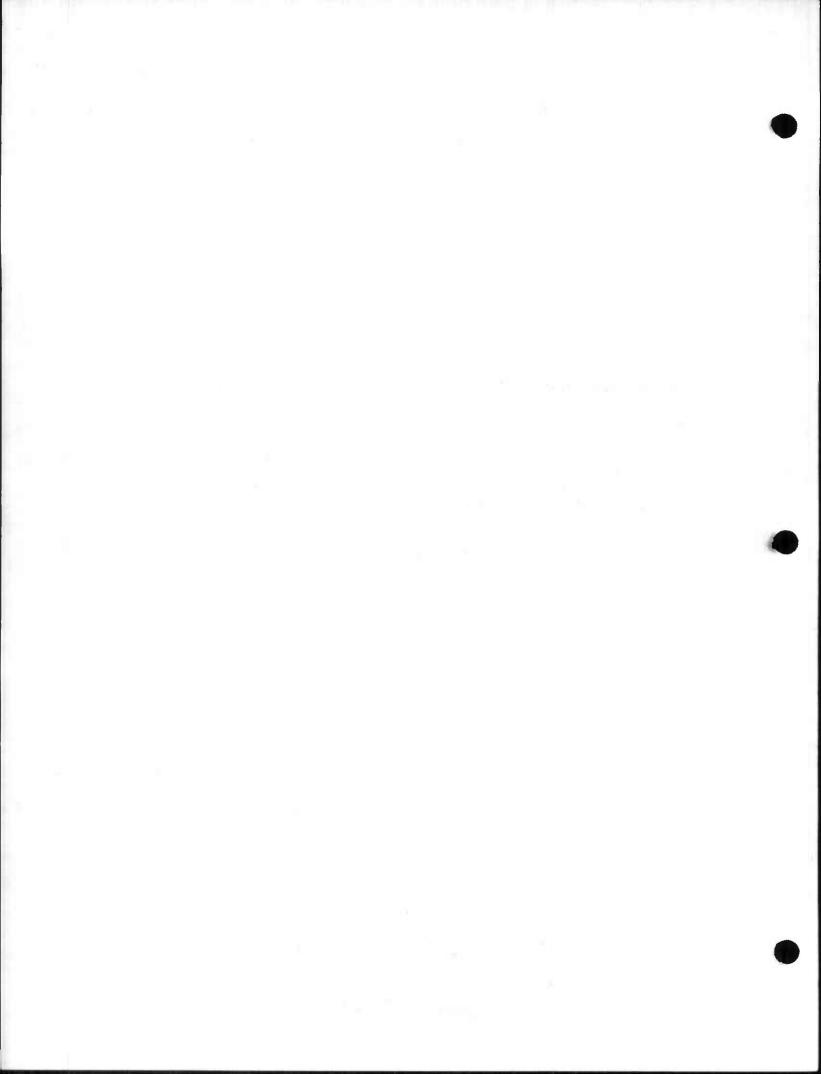
29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who complete d cause of death (Item 23e) (Type, Print) Eric Ciganek, MD, Route 213, Centreville, Maryland 21617

State Registrar

32. Registra's Signature

Suha Davidson-Randelle



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08044 Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Paul Clifton March 5, 1997 Starkey, Jr. /Medical 3:30 a.m. 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** Corsica Hills Nursing Home Centreville Queen Annes If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funerai** Months Days 1**X** M 2□ F 214-28-2913 64 Director July 16, 1932 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location show 10d. Inside City Limits notified at Director 1 Ves 2 □ No 28a-f s Maryland Queen Annes Centreville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 must be r therms 23a 107 Newnam Avenue 21617 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 11. Marital Status Wes Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian. Medical Examiner Bleck, White, etc. 1 Never Married 2 Married à altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3€ Widowed 4 □ Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry than Elementery/Secondery (0-12) College (1-4or 5+) Printer Publishing 16. Mother's Neme (First, Middle, Melden Sumeme) 17. Fether's Name (First, Middle, Last) Be 12 should be 1 n and Mental F is marked of Paul C. Starkey, Sr. Martha Estelle Sewell 19e. Informent's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If them 27 is m Paul C. Starkey, III/Son 107 Newnam Avenue, Centreville, Maryland 21617 20e. Method of Disposition 20b. Ptace of Disposition (Name of cometery, cremetory or other place) 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Chesterfield Cemetery/March 8, 1997 Centreville, Maryland vice Licensee Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Intastate Malyrant helanoma. Immediate Ceuse (Finel diseese or condition resulting In death) /Medical **Examiner** , Lung and (L) leg mete 2+ years Examiner certificate be executed physician and sthe burial-trans Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Box 68760 Physician/Medicai Due to (or es e consequence of): as P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown signed t Records, þ 24b. Were eutopsy findings evaileble prior to Completed 24e. Wes en eutopsy completion of cause of deeth? page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certification filled in by the funeral director; 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth Certification: 26e. Dete of Injury (Month, Dey Year) 26b. Time of 28c. Injury at Work? 26d. Describe how injury occurred 1 Natural 5 Pending Investigetion 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 26e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29e. Certifier Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner as steted. Medical 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

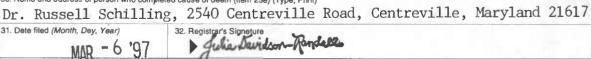
State Registrar

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31. Dete fited (Month, Dey, Year) -6

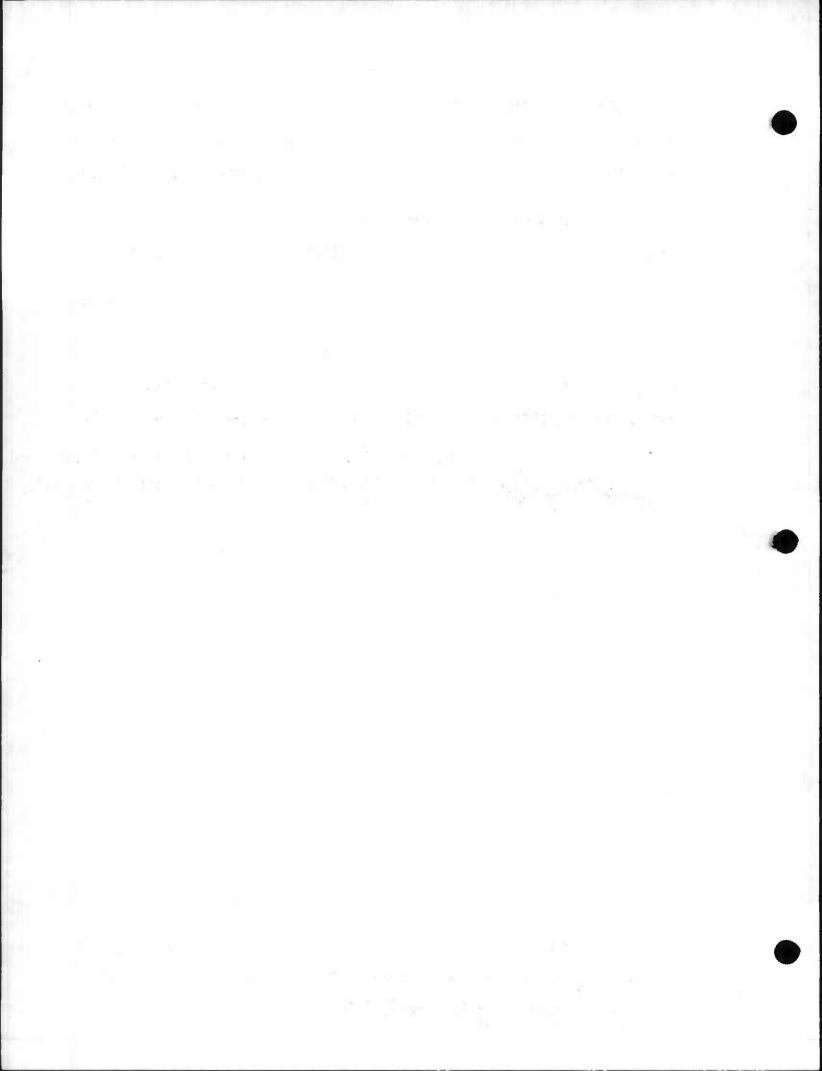
30. Name and address of person who completed cause of deeth (ttem 23e) (Type, Print)

29b. Signeture end title of certifier



29c. License number

29d. Date signed (Month, Dey, Year) March 5, 1997



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r 28e	irec	10e. Street end Number		31121	2110112	10f. Zip Code			10g. Citizen	of Whet Cour	ntry?	
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and N a mar a mar		19a. Informent's Name/Reletionship	(Type, Print)	GRAND 1	9b. Meiling	Address (Stree	t end Numbe	r or Rural Route Nu	m <i>ber, City</i> or To	vn, Stete, Zip	Code)	
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f of He		20e. Method of Disposition 1 X Burial 2 ☐ Cremetion 3	Removel from Sta	nom o	of Disposit	ion (Neme of tory or other ple	eca)	Dete		n - City or To	wn, Stete)
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within 24 hours after death. To the Funeral Director: After completely filled in by the funeral compl	edical C	29a. Certifier (Check only one) 1 Certifying P. 2 Medicat Exa	hysician: To the bes miner: On the basis end menner:	of examinetion	ige, death or and/or inves	ccurred et the ti	ime, date end opinion, deeti	pleca, end due to to n occurred et the tim	he ceuse(s) end le, dete and pled	menner es s a, end due to	tated. the ceus	ie(s)
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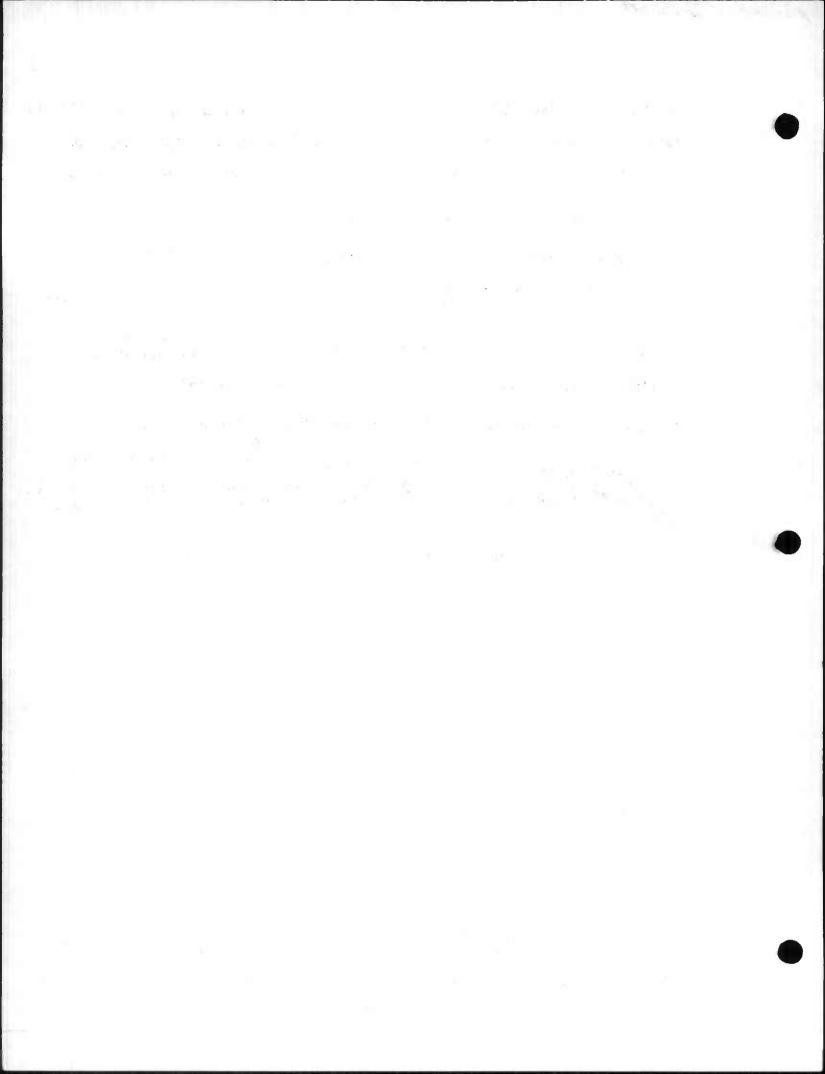
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			23a. Pert1. Enter the disease, or con shock, or heert failure. List onl	nplications that cause	d the deeth. Do	not enter th	ne mode of dyi	ng, such es cere	diec or respiratory	errest,		Approximate Interval Betw)
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	that the de- ned by the a detached f	Physicia	Pert II. Other significent conditions	contributing to death t	but not resulting	in the under	tying ceuse gi	en in Pert I.		tobacco use co			
	that ed b								1	Yee 2 10	3 Prof	bably 4 🗆 U	Jnknow
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	or Attend after death Director: / d in by the (Ific	3 Suicide 6 Could not I	289. Piece of in	jury - At home, fa	arm, street,	fectory, office		28f. Location	(Street end Numb	er or Rura	I Route Numb	ber,
i	d in the	Certification:	4 Homicide	building, et	tc. (Specify)				City or To	wn, Stete)			
	Hospital or, 24 hours afte Funeral Dire etely filled in I		29e. Certifier 1 Certifying Pi	hysician: To the best	of my knowledge	e, deeth occ	curred et the tir	ne, dete and ple	ce, end due to the	ceuse(s) end me	enner es si	teled	-
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical	(Check only 2 ☐ Medical Exa	miner: On the besis o	of examinetion er	d/or Investi	getion, In my o	pinion, deeth od	curred et the time	dete end place,	end due to	the ceuse(s)	
	within X within To the comple	M	29b. Signeture and title of certifier				29c. Licens	e number		29d. Date signe	d (Month,	Day, Year)	
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					<i>y</i>	_	2	1//	0	יייוויייי			/
			30. Name end eddress of person who		deeth (Item 23e)	(Type, Print	CAL-	PAI	APS CO	RATT	100.	1007	121
			JUICTH MUN	, D 7 1	MD	03	01071	11.11	11/2 (1)	1210	1. 10	3.00	-
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	Physic /Medi Examii	cai	1. Decedent's Name (First, Middle, Li ROLAND F	SEWELL restreet end number)	ITAL			4b. City, Town, or I	2. Dete of Domination MARU Location of Dee	Dey	Year 1997 Inty of Deeth	3. Time of Death 3:02 A m
	Funeral Director		5. Sociel Security Number 212-28-1233	Sex 7. Age (In)		mday) If Und Months	er 1 Year s Deys	if Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D June 9	rth ey, Year) , 193	9. Birthple Counti	ece (State or Foreign ry) yland
	ther death with the Maryland thems 23s or 23s-t show ther must be notified at	Director	Usuel Rasidence of Decedent			or Location						d. Inside City Limits
	ath with 23s or nust be		601 Cypress Ro	T			2114			US		
020	hours after de ural', or llams al Examinar n	by Funeral	11. Maritel Stetus 1 ☐ Never Married 25 Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No Ko If Yes, Give Yeer or Dates Co N	REAN	If Yes, sp	edent of I becify Cub 2 No	dispanic Origin? (Sen, Mexican, Puart Specify:	pecify Yes or No o Rican, etc.)		Race - America Bleck, White, e ecify:	
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	t and 2 sho Health and 8 Vm 27 is mai ther traums		19e. Informent's Neme/Relationship (Margaret Sewe 20e. Method of Disposition	11/wife	60		ress	end Number or Rus	everna	Park	, MD	21146
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760,	Physician /Medical Examiner pen	Examiner	Immediata Cause (Final disease or conditions, if eny, leeding to immediate cause. Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	e. Metas Due to	Latic	ot entar the mo	3 lac	.cnie Hw	or respiretory	rrast,	Park,	MD21146 Approximate Interval Between Onset end Deeth
Box 68	ifficate g phys	Physician/Medical	Cause (Disease or Injury thet initiated events resulting In deeth) Lest	d		nsequence of						
s, P.O.	requires that the death cer ween signed by the ettendin hould be detached for use	by Physic	Part II. Other significant conditions of	contributing to deeth but not	resulting In	the underlying	cause gi	van in Pert I.		tobacco use		the cause of death?
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ital	Pa ete	Be Co	25. Was case refarrad to medical					26. Placa of Daa		Yes 2 N	0 1 🗆	Yes 2□ No
of	Phys this rat di	2	axaminer? 1 Yes 2 No 27. Menner of Death 1 Natural 5 Pending investigatio	28a. Dete of tnjury (Month, Day Year	ER/Outp 28b. Tin		28c. inju Wo	ner: 4 Nurstng H	ome 5 Res 28d. Describe	idence 6 🗆		
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	To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After completely filled in by the funer	Medicai	29a. Certifier (Check only one) 1 P. Certifying Ph. 2 Medical Example 1 Medical Exa	ysicien: To the best of my k niner: On the basis of exam end mennar stated.	nowledge, inetion and/	or Invastigation	n, in my o	me, date end place opinion, daeth occu se number	, end dua to tha rred at tha tima	, data and pla	mannar as ste ce, and due to t gned (Month, D	the cause(s)
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	Sta Registr	_		197 Felia A	widson	Mande	•					



State of Maryland / Department of Health and Mental Hygiene

97 08048

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** Month Year Myrtle Slow 1997 March 1 1:55PM /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Genesis ElderCare -The Pines Easton Talbot | If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | Sept. 11, 1913 5. Social Security Number 9. Birthplaca (Stata or Foreign Country) Maryland 7. Age (in yrs. last birthday) **Funeral** 1□M 2∯F 83 Yrs Director 214-32-5987 Usuel Rasidanca of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits the Marylar Talbot 0xford 1 MYes 2 □ No Maryland Director notified 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8 event, the Medical Examiner must be USA 21654 "natural", or Itams 23a P.O. Box 51 Funeral 12. Wes Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuben, Maxican, Puarto Rican, etc.) 11. Marital Stetus 14. Race - American Indian, Black, White, atc. 72 hours after 1 ☐ Nevar Merried 2 ☐ Merried 1 ☐ Yas 2 ☑ No If Yes, Giva Yaar or Datas: Saltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Black. þ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Private Families 7th Domestic permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy,
Important: If flow 27 is marked other any Injury or other 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Meiden Sumama) Carroll Brooks Louise 19e. Informant's Neme/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Alice E. Banks / aunt P.O. Box 51, Oxford, Maryland 21654 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremetion 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) 3/6/97 Brooks Cemetery Trappe, Maryland 21. Signature of Funaral Seculos Licenses 22. Nama and Address of Fecility Bennie Smith Funeral Home Easton, Maryland 21601 234. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart fallure. List only one cause on each line. Approximata Interval Batween Onset and Deeth **Physician** /Medical Immediata Cause (Final diseasa or condition rasulting in daath) RESPIRATORY FAILUAE.

Dua to (or as a consequence of): Examiner LOWER ESO PHAGEAL

Dua to (oy'as a consequenca of): physician and the burial-transit Sequentially list conditions, if eny, leading to immediata causa. Entar Underlying Cause (Disaase or Injury that initiated avants resulting in deeth) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contributa to the cause of death? G LAY COMA 1 Yes 2 No 3 Probably 4 Donknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy DEMENTIA 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate To the Hospital or Attending Physicien: " within 24 hours after death."

To the Funeral Director: After this certifica 25. Wes casa rafarred to medical examiner?

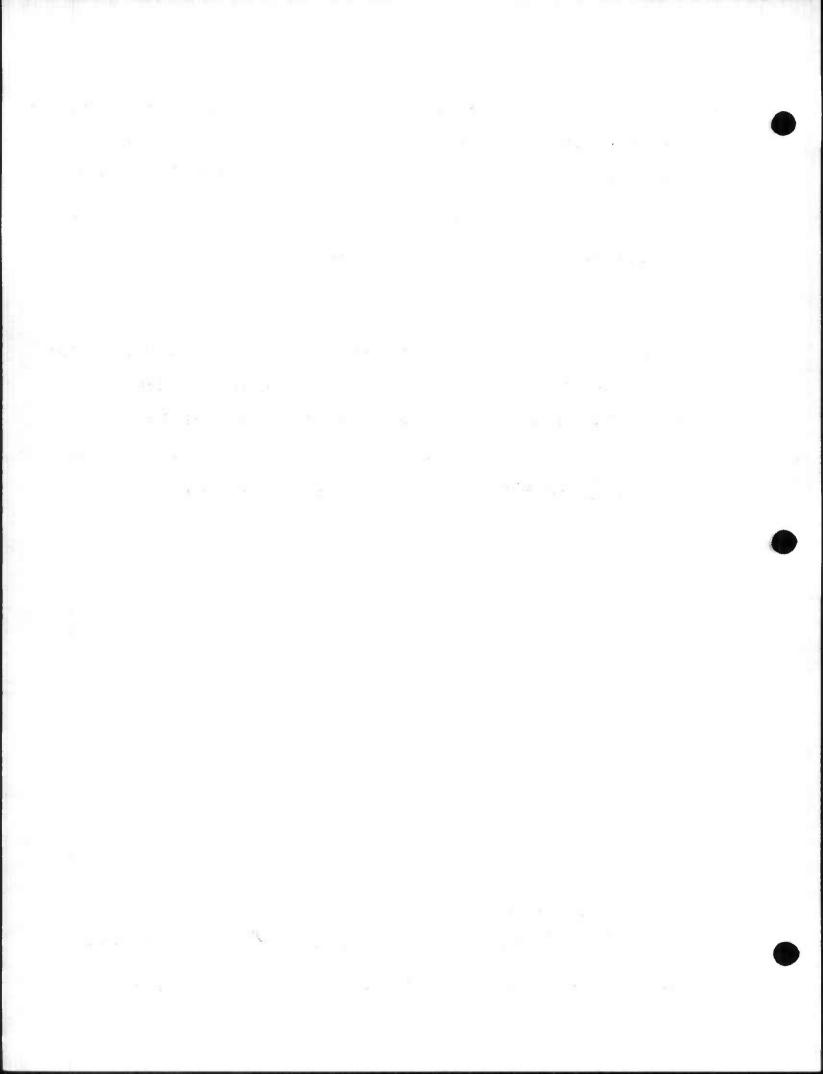
1 Yas 2 No Be 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death funeral 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? 28d. Dascribe how Injury occurred 1 PNatural 5 Pending Invastigation 1 ∏Yas 2 ∏No 2 Accidant within 24 hours after death To the Funeral Director: completely filled in by the 8 Couid not be determined 3 Suicide 28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Streat end Number or Rural Routa Number, City or Town, Stata) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and manner stated. Medical 29a. Certifiai (Check only one) 29b. Signeture end title of o 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) 508 FREWILD AUE EASTON, MD 31. Data filad (Month, Day, Year) 32. Registrar's Signatura State

The Tevidson-Randalle

MAR - 4 1997

Registrar



State of Maryland / Department of Health and Mental Hygiene 08049 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** FEB Month 1997 eer SWANN 28 LINDA 1:05 AM /Medical 4e. Facility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner THE MEMORIAL HOSPITAL EASTON TALBOT | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | Months | Deys | Hours | Min. | NOV • 3 , 1958 5. Social Security Number 7. Aga (In yrs. lest birthday) **Funeral** Birthplece (State or Foreign Country) 1 M 2 F 38 214-70-6121 Yrs Director MARYLAND Usual Residence of Decedent 10b. County 10e. Stete 10c. City, Town or Location 28a-f show 10d. Inside City Limits must be notified MD CAROLINE PRESTON Directo 1 ☐ Yas 2X No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 23a 5100 FRAZIER NECK ROAD by Funeral 21655 USA thems: 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, etc.) 14. Rece - Amarican Indian, the Medical Examiner Black, White, etc. 72 hours after 1 Nevar Married Married 1 ☐ Yes 2 MNo It Yes, Give Yaar or Dates: 21215-0020 ò 1 ☐ Yes 21 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: WHITE 'natural' Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) 11 HOUSEWIFE OWN HOME Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 Mental marked CHARLES F. DRAPER Pages 1 and 2 should traumatic DOROTHY MAE BILBROUGH and a 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Justinent of Health Important: If item 27 is any Injury or other 9006. \$AMMY D. SWANN/HUSBAND 5100 FRAZIER NECK ROAD, PRESTON, MD 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) Dete 20c. Location - City or Town, Stete 1 Burlal 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) GREENSBORO CEMETERY 3 - 4 - 97GREENSBORO, MD 21. Signature of Funaral Service Licensaa 22. Name end Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME JOHN R. MERCERON 200 S. HARRISON ST. EASTON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrast shock, or heart feilura. List only one cause on each line. Approximeta Intarval Betwean Onset end Deeth Physician /Medical Immediate Cause (Final METASTATIC SQUAMOUS CANCER URINARY BLADDER disease or condition resulting in deeth) Examiner 6 MONTHS Due to (or es e consequence ot): The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Last and Due to (or es e consequence ot): nding physician a Box 68760. Physician/Medical Due to (or as e consequence ot): ed by the a Pert II. Other eignificent conditione contributing to death but not resulting in the underlying ceuse given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yee 2 No 3 Probably 4 ☐ Unknown signed t þ 24b. Were eutopsy findings available prior to completion of ceuse of death? Completed 24e. Wes an autopsy performed? page 2 2 No certificate 1 Yas 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes cese reterred to medical exeminer? 8 28. Plece of Deeth (Check only one) Hospitel: 1 Inpatiant 2 ER/Outpatient 3 DOA 2 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) After this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Certification: 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled the Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner steted. Medical 29a. Certifier (Check only one) 29b. Signature end title of certifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) D 38990 Feb. 28, 1997 30. Neme end eddress of person who completed causa of death (Item 23e) (Type, Print)

404 Marvel Ct.

Pandalle

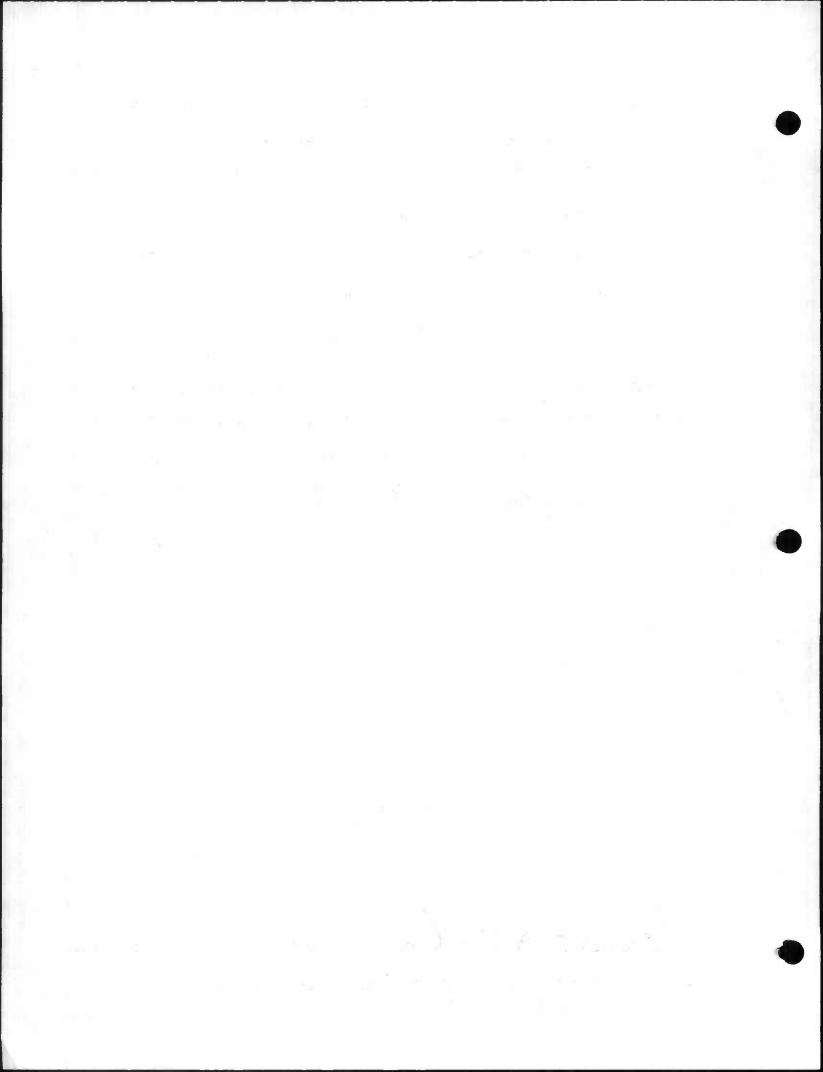
32. Register's Signature

Easton, MD 21601

State Registrar Charles DiNapoli MD

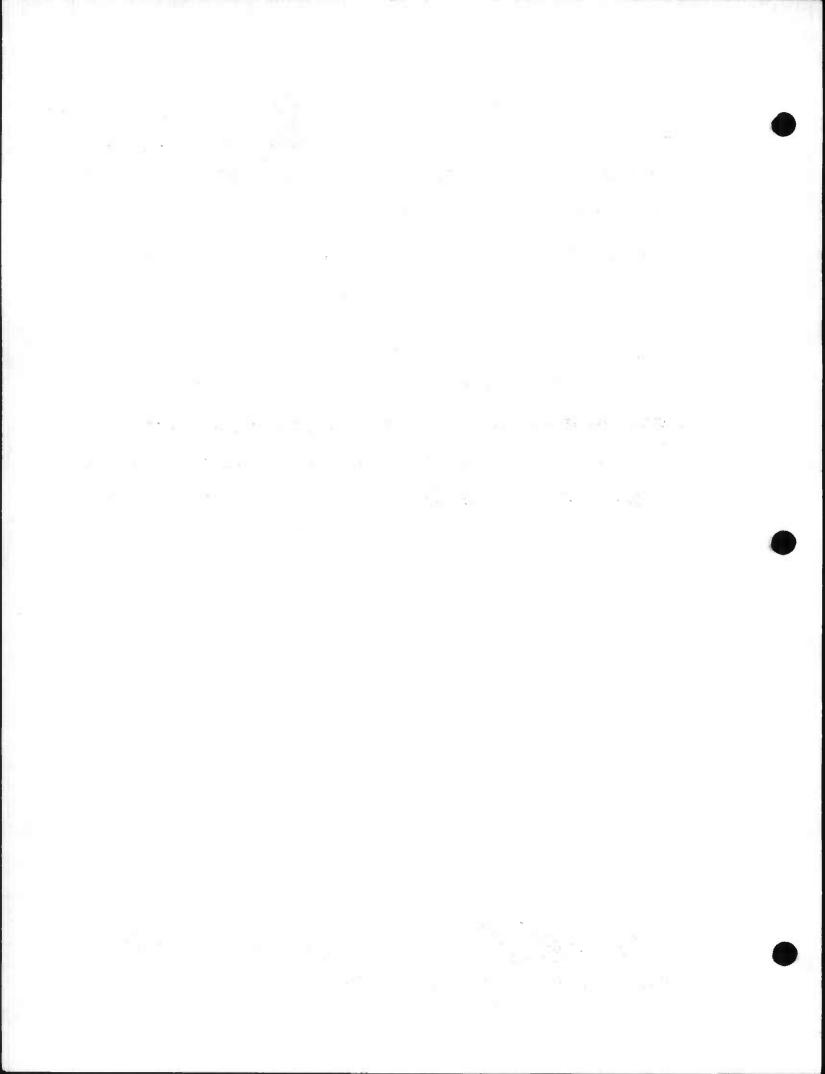
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31. Dete tiled (Month, Dey, Year)



State of Maryland / Department of Health and Mental Hygiene

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ı	Examir	ner	4a. Facility Nama (If not institution,	giva street and number;				4b. City, Town, or Loc		4c. County	of Death		
			P.R.M.C. 5. Social Security Number	S. Sex 7. A	no do um locable	at at a 1 H L In	ndar 1 Yaar	SALISBURY If Undar 24 Hrs.		WICO			
0	Funerai Director		218-34-8377 Usual Rasidance of Dacedent	1□M 2ÅF	ge (In yrs. last bii 60	Yrs. Mont		Hours Min	B. Data of Birth (Month, Day, JAN. 27	Year) 1937	9. Birthp Coun	laca (Stata o try) MD.	r Foraign
	pund # #		10a. Stata 10b. County		10c. City, Tow	n or Location					1	0d. fnsida Cl	ty Limits
	with the Marylar a or 28e-f show the notified at	Director	MD. WICOM	CO			VILLE					1 🗆 Yas	2X No
	har death with the Maryla Berns 23a or 28a-f show free must be notified at	al Dire	10e. Street and Number 7292 PINE ST.			10f.	Zip Coda 21850		10	g. Citizen of V		try?	
020	g 9 5	by Funeral	11. Marital Status 1 ሺ Nevar Marriad 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedant Armed Forcas 1 ☐ Yas 2 ☒ If Yas, Giva Yaar or Datas:			ecedant of H specify Cuba s 24 No	lispanic Origin? (Spec an, Maxican, Puarto R Specify:	ify Yas or No- ican, atc.)	Blac	e - Americ k, Whita, WHIT	atc.	
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lar	thould be ad Mental merked o	To B	HOWARD V	TAYLOR,	SR.			ELLA	SHIFFE	R			
Maryland	2 should and Men is merke eumetic		19e. Intormant's Name/Ralationshi	(Type, Print)	198	. Mailing Add	ress (Street	end Number or Rural	Routa Number,	City or Town,	Stata, Zip	Code)	
			PAULINE RECORDS	- SISTER	7	310 PI	NE ST	.,PITTSVIL	LE.MD.	21850			
Baltimore,			20a. Mathod of Disposition		20b. Placa o cemate	f Disposition (ry, cramatory	Nama of or othar plac	ce)	Data 2	0c. Location -			
Ė	Department of important: If any injury or ance.		4 Donation 5 Other (Spe 21. Signature of Edneral Service Li		PITTE	VILLE 22. Name		SS of Facility	/6/97 P	ITTSVII	LE, M	D.	
Ba	Dep Impo		> Quald	1/2	ineS	/		ERAL HOME,	SALISBU	RY,MD.	218	04	
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	Physician // // // // // // // // // // // // //		fmmediata Causa (Final	1	11-	-		at 6,	+			Onsat and I	Death
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		9			Dua to (or as a	consequance	of):				į		
	tificate be executed ig physician and as the burlat-transit	Examiner	Sequentially list conditions,	b	Dua to (or as a	consequence	of):						
60,	be ex ician burial	a E	Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Diseasa or Injury that initiated events.	c									
68760,		Medical	resulting In death) Last		Dua to (or as a	consequanca	of):						
Вох	eath cart attendin for use	Physician/		d							1		
	e dea	sici	Part II. Other significant conditions	contributing to death t	out not resulting I	n tha underlyir	ng causa giv	ren in Pert I.	23b. Did tot	acco uss cor	ntribute to	the cause o	of death?
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æ	The law ate has t	E							1 □ Ya	s 2-100		Yas 2	No
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>	5 00	TOE	axaminar?	Hospital:	ant 2 ER/O	utpatient 3□	DOA Oth				ar (Specifi	()	
on of	De le le		27. Mannar of Death Natural 5 Panding Accident Invastiga	28a. Data of Inju (Month, Da		Tima of Injury	28c. Injur Wor	yat k? Yes 2 □ No	3d. Dascribe ho	w injury occurr	ed		
Division	or Attending after death. Director: After	Certification:	3 Sulcida 6 Could no 4 Homicida datamin	t be 28a. Place of In	jury - At homa, fa c. (Specify)	ırm, streat, fac	ctory, office	21	8f. Location (Str. City or Town,		er or Rura	l Routa Num	ber,
	Hospital 24 hours Funeral tely tilled	edical C	29e. Certifiar (Check only one) 29e. Certifying 2 Madical Ex	Physician: To the best aminer: On the basis of	t axamination an	o, deeth occuri d/or invastiget	red et tha tir tion, In my o	ne, dete and placa, ar pinion, daath occurre	id dua to the ca d at tha tima, da	use(s) end ma ta and place, a	nner as st	ated. tha cause(s	<i>i</i>)
	To the within 2 To the comple	ĕ E	29b. Signature and tWiftof certifier	and mannar st	ated.	-	29c. Licans	a number	29	d. Data signe	d (Month.	Dav. Year)	
	F 3 F 8		· Chale	lunde				30853		3/3/	97	7	
	2		30. Nama and addrass of person w	no complated causa of c	death (Item 23a)	(Type, Print)	RMC			, ,			
	0	•	31. Data tiled (Month. Day. Year)	Ilvia Ju	Langin (Anda	4	Karic						
	Sta Registr	_	MAR U3 199	Jana									



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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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	FOR 1 - STATE REGISTRAR	STATE OF MAR	YLAND / DE	PARTMEN	NT OF H	EALTH DE AT	AND M	IENTAL HYGIE			00031		
	1. DECEDENT'S NAME (First, Middle, Last)	CERTIFICATE OF DEATH						2. DATE OF DEATH			3. TIME OF DEATH		
FUNERAL DIRECTOR	ANITA	н.			,	EBRUARY 2			R				
	4. SOCIAL SECURITY NUMBER	5. SEX 6. A	X 6. AGE (In yrs. lest birthde			IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.				S. BIRTH	BIRTHPLACE (State or Foreign		
	222-14-4183	1 🗆 M 2 💢 F	M 2 💢 F 71 YRS.			HOURS	MIN.	SEPT. 29, 1925 1			Country) PENNSYLANTA		
	9a. FACILITY NAME (If not institution, give street and number)			9b. CITY, TOWN OR LOCATION							TY OF DEATH		
	ATLANTIC GENERA		BERLIN					STER					
	10a, STATE 10b. COUNTY			10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS?			
	DELAWARE SUSSE	EX	SELBYVILLE							1 TYES 2 NO			
	10e. STREET AND NUMBER		101. ZIP CODE					10g. CIT12	EN OF	WHAT COUNTRY?			
	232 RIVER RUN			19975						US	USA		
	11. MARITAL STATUS 1 Never Married 2 X Married		RCES? 1 YES 2 NO If yes, specify Cub			ecify Cuba	F HISPANIC ORIGIN? (Specify Yes or No- 14. RAIn, Maxican, Puerto Rican, etc.)				CE — American Indian, ack, White, etc.		
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR O	1 TYES 2 X NO Speci							Specify: WHITE			
COMPLETED	15. DECEDENT'S EDU	16a, DECEDE	16a. DECEDENT'S USUAL OCCUPATION				16b. KIND OF BUSINESS/INDUS						
	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give kin	nd of work don VOT use retired	e durina ma	st of workin	g	IOU. KIND OF S	OSINESS/INDI	JOINT			
	Estimated (0-12)	2	HOMEMAKER					OWN HOME					
	17. FATHER'S NAME (First, Middle, Last)						NAME (First, Middle, Melden Surname)						
BE C	GLENN HOFFHEISER						VanZandt						
	19a. INFORMANT'S NAME (Type/Print)		19b. MA	ILING ADDRE	SS (Street a	-		oute Number, City or To	own, State, Zip	Code)			
2	J. MAX TRAPP JR.		232	RIVER	RUN.	SEL	BYVII	LLE, DELA	WARE 1	997	5		
	20a. METHOD OF DISPOSITION	count from State	20b. PLACE AND D	ATE OF DISPO	SITION (Na	me of			OCATION — C				
	1 Deurstie 2 A Cremetton 3 Removal from State SALISBURY CREMATORY 2/28/97 SALISBURY, MD									, MD			
	21. SIGNATURE OF FUNERAL SERVICE LIC		22. NAME AND ADDRESS OF FACILITY										
	1 Charles 4	V Had)	H	ASTIN	IGS F	UNERA	AL HOME, S	ELBYVI	LLE	, DE 19975		
CERTIFICATION	23. PART I. Enter the diseases, or a shock, or heart fellure. IMMEDIATE CAUSE (Final	n each lina.	eth. Do not antar the mode of dying, such as cardiac or respiratory arrest,						eat,	Approximata Interval Between			
	disease or condition resulting in death)	213							Onset and Death				
	resouring in death)	DUE TO (OR	AS A CONSEQUEN	NUENCE OF):						10			
	Sequentially list conditions	andillone b. Deffler								3-4 days			
	Sequentially list conditions, if any, leading to immediate												
할	CAUSE (Disease or Injury												
Ē	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST												
PHYSICIAN: MEDICAL CEF	d												
										. WERE AUTOPSY FINDINGS			
							PERFORMED?			COMPLETION OF CAUSE OF DEATH?			
										1 YES 2 NO			
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN												
	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one)												
YSI	1 TES 2 NO	1 Inpatlant 2 - ER/	Outpatient 3 🗆 Do	OA 4 N		o 5 ☐ Res	sidence 8	Other (Specify)					
F	27. MANMER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF UNJURY WORK?							28d. DESCRIBE NOW INJURY OCCURED					
BY	2 Accident Investigation		M 1 YES 2 NO										
	3 Suicide 6 Could not be 4 Homicide determined	URY — Al home, fi Specify)	ne, farm, street, factory, office 28f. LO				28f. LOCATION (Stree City or Town, Stat	LOCATION (Street and Number or Rural Route Number, City or Town, State)					
E .	AA. ACPOUNCE												
절	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.												
COMPLETED	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.												
BE	29% SIGNATURE AND TITLE OF CERTIFIER 20c. LICENSE NUMBER.							ER	29d. DATE SIGNED (Month, Day, Your)				
TO E	100m (avent m) 1976/16 12/28								8/77				
	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF	DEATH (ITEM 27)	11			~	Λ					
	BSHER I DUIL	IMAT, MO	4733	HER	HAL	DAY	DB	- MER	410,1	n	21811		
	31. DATE FILED (Month, Day, Year) EER 28 1997	THE SHIP OF SHIP	IGN HIBELALL										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Dey TAYLOR 24 FEB. 1997 8:20 P.M. 4a. Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 4672 SNOW HILL ROAD SALISBURY WICOMICO If Undar 1 Yaar Months Days 8. Data of Birth (Month, Day, Year, JULY 19 1 If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country)
 MD • Months Hours 1 X M 2 □ F Yrs 84 10c. City, Town or Location 10b. County 10d. Insida City Limits WICOMICO SALISBURY 1 ☐ Yas 2 No 10g. Citizan of What Country? 10f. Zip Coda 4672 SNOW HILL ROAD 21804 U.S.A. 12. Was Dacedant Evar In U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 X No If Yas, Giva 1 Nevar Married 2 Married WHITE 1 ☐ Yas 2 No Specify: 3 X Widowed 4 Divorced Yaar or Datas: 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collage (1-4or 5+) INDEPENDENT RETAILER FUEL OIL 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Melden Sumama) CHARLES P. TAYLOR MARY ELLEN HITCH 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 1400 ROBINS AVE,, SALISBURY, MD. 21804 SYLIVA DISHAROON-DAUGHTER 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20c. Location - Cify or Town, Stata Data 1K Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 3/1/97 PARSONS CEMETERY SALISBURY, MD. 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility BOUNDS FUNERAL HOME, SALISBURY, MD. 21804 234. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha mode of dying, such as cerdiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximata Interval Batwean Onsat and Death Metaslatu Ca of Prostote Grand June 96 Dua to (or as a consequanca of) Dua to (or as a consequence of): Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Thelletons 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yas No 1 Yas 25. Was casa refarred to medical axaminar? 26. Place of Deeth (Check only one) 2DER/Outpatient 3 DOA Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Inpatiant 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding Invastigation 1 Yes 2 No 6 Could not be determined 28a. Place of Injury - At home, farm, streat, factory, offica building, atc. (Spacify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and place, and due to the causa(s) end manner as steted.

Madical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760,

physician and s the burial-transit certificate be executed 98 use 8 peen 198 this funeral or Attending F efter deeth. Director: After After To the Hospital or Atterwithin 24 hours after der To the Funeral Director completely filled in by the

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permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is ma any Injury or

Physician

/Medical Examiner

Maryland 21215-0020

5. Social Security Number

214-10-9070 Usual Rasidance of Decedant

10e. Street and Number

20a. Method of Disposition

Immediata Cause (Final disaasa or condition rasulting in death)

Sequantially list conditions, if any, leading to immadieta cause. Entar Underlying Cause (Disease or Injury

that initiated events resulting in daath) Last

1 Yas PONo

27. Manner of Death 1 Auturai 2 Accidant

3 Suicida

29a. Cartifian (Check only one)

4 Homicida

Male

11. Marital Status

10a. Stata

MD.

Registrar

INTERNAL MEDICINE 31. Data filed (Month), 88. WHY FORD ST. 35 195 Far's 9 Pature SALISBURY, MD 21804

FEB 26 1997 Julia Davidson Randall

30. Name and The HUDDLESTONES OINARD (INARA) (Type, Print)

14 (CA)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day 1997 **Physician** Elwath Tawes 045 A March 1, /Medical 4a. Facility Nama (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crisfield Somerset Edw.W.McCready Memorial Hospital If Under 1 Year If Undar 24 Hrs. 8. Deta of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Deys Months 1**X**0 M 2□ F 76 219-01-6779 **Director** July 17, 1920 Maryland Usual Rasidence of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Norms 23s or 28a-f show the Medical Examiner must be notified at 1 ☐ Yas 2 XNo Somerset Crisfield Director Maryland 10e. Street and Number 10f. Zio Coda 10g. Citizan of What Country? 5221 Frances Road 21817 USA Funeral 12. Was Decedent Ever in U,S. Amped Forcas? 1 M Yes 2 D Neworld If Yas, Give Yaar or Datas: War II 13. Was Decedent of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black. Whita, atc. be filed within 72 hours after 1 Nevar Married 2 Merried b Baltimore, Maryland 21215-0020 1 ☐ Yas 2 A No Specify: þ Specify: White 3 M Widowed 4 □ Divorced "netural", Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Business/Industry MD Dept. of Employment al Hygiene. Collega (1-4or 5+) Elementary/Secondary (0-12) Manager Office 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be 2 should be and Mental I is marked of I. George Tawes Sadie Webb 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) permit. Pages 1 and 2 at Department of Health and Important. If hem 27 is a any injury or other traum page. 11545 S. Somerset Ave. - Princess Anne, MD 21853 E. Scott Tawes (son) 20b. Place of Disposition (Name of camatary, crematory or other pleca) 20a. Mathod of Disposition Deta 20c. Location - City or Town, Steta 1 Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Sunnyridge Memorial Park 3/4/97 Crisfield, MD 21. Signeture of Funaral Sarvice Licansea

Rus Lulli. Paleu Llucur 22. Nama end Address of Facility
Bradshaw & Sons Funeral Home Robert H. Bradshaw 306 W. Main St. - Crisfield, 21817 23a. Part1. Entar tha diseasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haert feilura. List only one cause on each lina. Approximata Intarvai Between Onsat end Deeth **Physician** /Medical immediata Causa (Finel a. Biliary Sepsis

Dua to (or as a consequence of): disease or condition rasulting in death) Examiner Examiner 1-aiture Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the ettending physician and burial-transit Sequentially list conditions, if eny, laeding to Immadiata causa. Entar Undarlying Ceusa (Diseasa or injury that initiated avants rasulting in deeth) Lest and Dua to (or as a consequence of) Box 68760. ettending physician for use es the buria Physician/Medical Dua to (or as e consequence of): signed by the e Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. Division of Vital Records. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Wara autopsy findings eveilebia prior to completion of causa of deeth? Completed 24a. Was an autopsy performed? 2 No 1 Yas 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: 1Xinpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 8 ☐ Other (Specify) 2 No Certification: To 1 Yas funeral 28a. Data of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding investigation 1 Naturai 1 | Yas 2 | No 2 Accidant 6 Could not ba 3 Suicida Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, straet, factory, office building, etc. (Specify) á 4 I Homicida 24 hours a Certifying Physician: To the best of my knowladga, death occurred et the tima, data end place, and dua to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or invastigetion, in my opinion, death occurred at the tima, data and place, end due to the ceuse(s) and manner steted. edical 29a. Cartifian (Check only one) within 2 100 29b. Signature end title of cartifiar 29c. Licensa number 29d. Data signed (Month, Day, Year) 0 a -e D 48098 30. Nama and address of person who complated cause of deeth (Item 23e) (Type, Print) Vijay Karumbunathan, M.D. - 201 Hall Highway - Crisfield, MD 21817 Year) 32. Ragistrar's Signatura 31. Data filed (Month, Day, Year) State MAR 0 5 1997 Registrar

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State of Maryland / Department of Health and Mental Hygiene

Physician	_	1. Decedent's Neme (First, Middle, Le	st)	TURPI			2. Dete of De Month	Reg. No.	Yeer	3. Time of Death	
/Medical		TUESIONT	<u>L</u> .		Februa	uary 25 1997		11:25PM			
Examiner	ľ	4e. Fecility Name (If not institution, given VAMDHCS	e street end number)	4b. City, Town, or L							
neral rector	VAMDHCS Perry Point Ceo 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) Yrs. Wonths Deys Hours Min. Months Deys Hours Min. Month Day, Year 905						O Distributes	a (State or Foreig			
ified at	10e. Stete 10t. County 10c. City, Town or Location						10d. Inside City ⊔ 1 ☐ Yes 2Ø				
or thems 23s or 28s-1 sho miner must be notified at Funeral Director		100 Street and Number 281 218					68			an of Whet Country?	
<u>a</u>	2	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 □ No If Yes, Give Yaar or Dates:	.? If Yes, specify Cuben, Mexican, Pue No 1 ☐ Yes 2 2 No Specify:				14. Rec Ble Specif	ck, White, atc.	Amarican Indian, White, atc.	
Be Completed		15. Decedent's Education (Specify only highest grada completed) Elementary/Secondery (0-12) College (1-4or 5+) 16e. Decedent's Usuel Oc (Give kind of work do life. DO NOT use re				during most of work d)	16b. Kind of Business/Industry Custod:an				
		17. Fether's Name (First, Middle, Last) EMANUEL JUYPIN 18. Mother's Name (First, Middle, Meiden Surneme) Elizabeth Waters									
other traumatic event, 1		DOROHEA 20e. Mathod of Disposition	laikes		ASTEIN	Parkway	AP1.30	Brook	lyn A4	11216	
injury or o		1 Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif	Removel from Stata	ALERS FA	Mily C	emotery .	3-1-97	Upper	Hill,	MD	
SUCE		21. Signature of Funeral Service Licer	low	30	439 H	E. Ward	16 Plin	cess An	no, MD	21853	
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es the bur		Sequentially list conditions, f eny, leeding to immediate cuse. Enter Undarlying Cause (Disease or Injury het initiated events asulting in death) Last	c Due to (or es e consequence of):								
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director director	2	25. Wes case referred to medical exeminer? 1 Yes 2 No						ne)		95 Z NO	
funeral Ion: T	2	7. Menner of Deeth 1. Netural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Dey Year) 28b. Time of Injury Injury M 28c. Injury et Work? 1 □ Yes 2 □ No					Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred			
filled in by		4 Homicide determined determined building, etc. (Specify)					28f. Location (Street end Number or Rural Route Number, City or Town, Stete)				
completely filled in by the		29a. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) and menner es steted. Check only one) Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner stated.									
00	2	29b. Signature end till ef certifier 29c. Licansa number D42800					29d. Dete signed (Month, Dey, Year)				
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State of Maryland / Department of Health and Mental Hygiene

08055 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death March **Physician** 06 199 Year MARY VTRGTNTA THOMAS 8:45 am /Medical 4a. Facility Name (If not institution, give straet and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 5537 Sharptown Rd. Eldorado Dorchester Hours Min. 8. Date of Birth (Month, Dey, Nov. 20 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 9. Birthplaca (State or Foreign 1 M 27 F Maryland 219-01-6558 84 Yrs. Nov. 1912 Director Usual Residence of Decedent with the Maryland Hygiene. other than "netural", or items 23e or 28e-f show ont, the Medical Evantiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Dorchester Eldorado Director 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 5537 Sharptown Rd. 21659 death Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ♣No If Yes, Giva 11 Marital Status Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) Race - American Indian, Black, Whita, atc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: white Be Completed by 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Dacedant's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) school teacher public schools permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked oths any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumema) Balvin В. Brinsfield Anna Truitt 2 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Code) William W. Thomas Jr. - son 5537 Sharptown Rd., Rhodesdale MD 21659 20a. Method of Disposition 20b. Place of Disposition (Neme of cometery, cremetory or other plece) 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Removal from State E. New Market Cemetery 3-8-97 E. New Market Md. 4 Donation 5 Other (Spacify) 21. Signature of Funaral Sarvice Licensaa 22. Name and Address of Facility Thomas Funeral Home PA Th 700 Locust St. Cambridge MD 21613 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final disaase or condition resulting in death) Examiner WKINSONS DIFERCE To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should he standard for use as the profession. Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disease or Injury Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai that initiated evants rasulting in death) Last Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use/contribute to the cause of death? à□/No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to. Completed 24a. Was an autopsy completion of cause of death? A No 2 1 No 1 Yes 25. Was case referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 2 N 1 Yey 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? Certification: 28b. Tima of 28d. Describe how Injury occurred 1 (Sulatural 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datermined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

| Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifian (Check only one) 29b. Signature and title of certifier 29c. Licanse number 29d. Date signed (Month, Day, Year) Highup Lawel, OF 32. Registrar's Signature

Randall 31. Date filed (Month, Day, Year) State 7 1997 Registrar

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** TAylor OIIO AM Darrell /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town or Location of Death 4c. County of Death Examiner Arunde Arunde Mospital Hen Bur Die Md Anne If Under 1 Yeer | If Under 24 Hrs. Birthplace (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M M 2 □ F 390-34-9057 Yrs Director 60 Feb 17.1937 Wisconsin Usual Residence of Decedant The Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits rail, or items 23s or 26s-f show Examiner must be notified at MD Anne Arundel Pasadena 1 ☐ Yas 2 ☑ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? William 21122 USA 224 List Avenue r death v Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If flem 27 is marked other in any injury or other branched other. 12. Was Dacedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11 Merital Status 1 ☑ Yes 2 ☐ No If Yas, Giva Yaar or Datas: 1 ☐ Nevar Married 2 ☑ Married 1 Yas 2 No by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highast grade complated) 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Eiamantary/Secondery (0-12) College (1-4or 5+) U.S. Postal Service Letter Carrier 4 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Be Floyd Taylor Mabel Noves 0 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Patricia Taylor/wife 224 List Avenue, Pasadena, MD 21122 20b. Piace of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Dete 20c. Location - City or Town, Stata Mar 5 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Maryland Veteran Cem. 1997 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD Barranco & Sons, P.A. Severna Park Funeral 21. Signetura of Funarai Service Licensee 495 GovRitchie Hwy., Severna Park, MD21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediata Cause (Finel METASTATIC Now SMALL COLL Lunia GARGNOMA SHUNTIS disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last Dua to (or as e consequence of): Ician/Medical Dua to (or as e consequence of) 88 980 Po signed by the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Phys 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to completion of causa of daath? 24a. Was an autopsy performed? page 2 s hes certificate 1 Yas 2 No 1 Yas 2 No funeral director, Be 25. Was casa rafarred to medical axaminar? 28. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 1 Yas 2 No 1 🗹 Inpatiant Certification: To 2 ER/Outpetient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury et Work? After 1 Naturel 5 Panding death. 1 Yas 2 No Investigation 2 Accidant 6 Could not be datamined

Division of Vital Records, P.O. Box 68760, or Attending Physician: efter deat Director: ne Hospital or Atte n 24 hours efter de ne Funeral Directo bletely filled in by ti To the Hosp within 24 ho To the Fune completely fi

29a. Cartifia (Check only one) 29b. Signature end title of certifiar

3 ☐ Suicida

4 Homicide

2 Medical Examiner: On the bests of examinetion and/or invastigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and mennar stated.

29c. Licansa number

15 certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and mannar as stated.

29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

31. Data flied (Mortth, Day, Year)

MA

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

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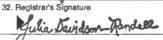
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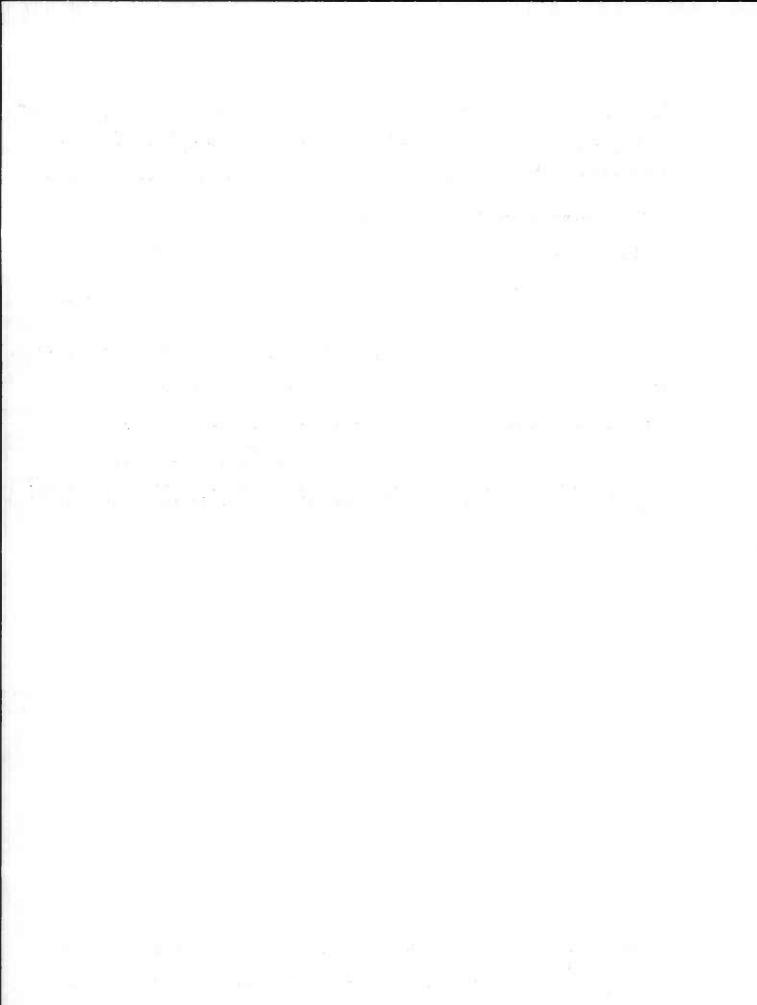
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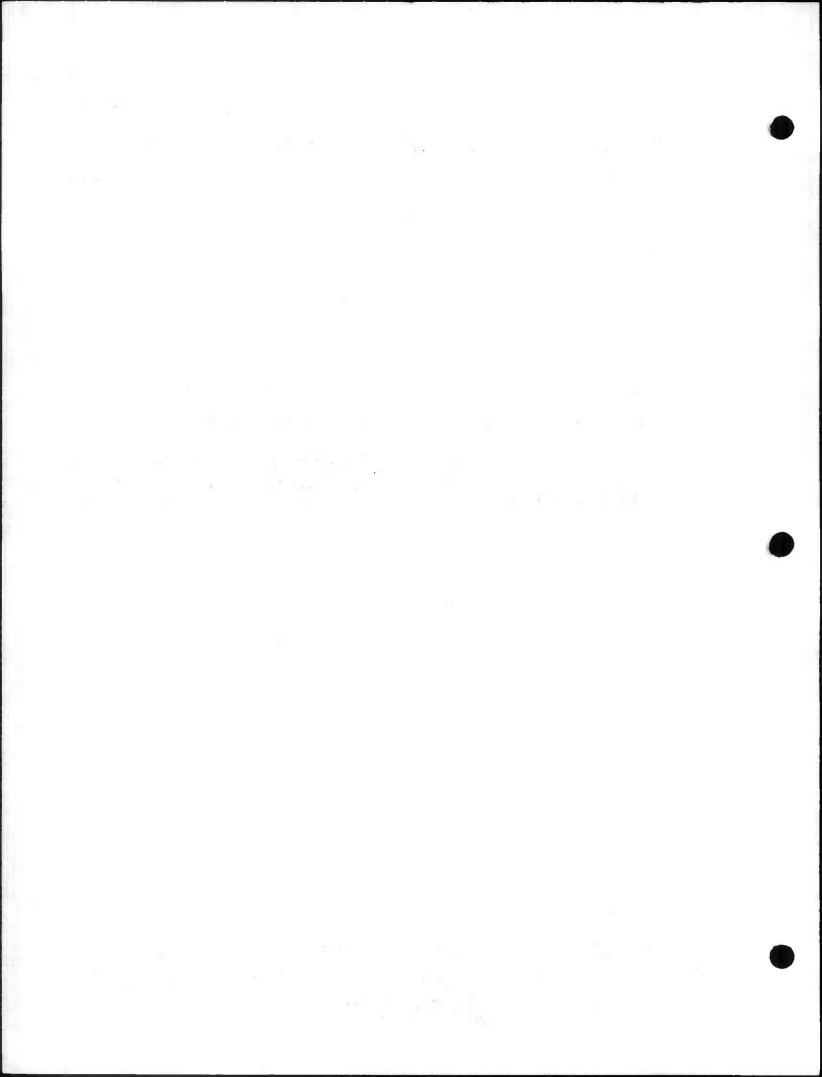




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State Registrar 31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

08058 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Leath Month Day Vost **Physician** Warren HEARD WARREN February 2 1997 cation of Death 4c. County of Death 0715 /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 12/28/1912 If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys NOMM 2□ F 84 Yrs Director 147-10-3931 Georgia Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2□No r 28a-f s notified Director Md. Wicomico Bivalve å 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7 is marked other than "nature", or items 23e or traumetic event, the Medical Examiner must be r 3347 Elsey Church Road 21814 U.S.A. Funeral 12. Was Decedent Ever In U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Datas: 1 Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Black \$ 3 Widowed 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Steel Worker 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ollie Warren 2 Catherine -----19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cristine V. Abercrombia 81 Williamson Ave, Hillside, N.J. 07205 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Type Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) EVERGREEN CEM. 11/15/10 21. Signature of Funerel Service Licensee 22. Name end Address of Facility
Messick FUNERAL Home, M00 - 417P.O. Box 61 Bivalve, Maryland 21814 23a. Part1. Enter the disaase, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** OP /Medical Immediata Causa (Final disease or condition rasulting in daath) Examiner Due to (or as a consequence of): Examiner certificate be executed physician and s the buriel-trans Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that infliated evants resulting In death) Lest Due to (or es a consequence of): P.O. Box 68760 Physician/Medical Due to (or es e consequence of): 80 for use es ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 3 Probably 4 ☐ Unknown 1 Tes 2 No Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? elu monia 24a. Was an autopsy performed? Completed page 2 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical Be 28. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? After 1- Naturat 5 Pending or Attending after deeth. investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piace of Injury - At home, farm, street, fectory, offica building, etc. (Specify) in by 4 Homicide To the Hospital o within 24 hours at To the Funeral D bellif yletelamos Certifying Physician: To the best of my knowledge, daath occurred at the time, data and place, and due to tha causa(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner steted. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifian 29d. Date signed (Month, Day, Year) 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

No. 10c milker / Street. Solisburg and 2180) 37 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 03 1997

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State of Maryland / Department of Health and Mental Hygiene

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Division of Vital Records, or Attending Physician: The law requires the after death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Re Completed by				, , ,	/					0		14a, Was	an eutopsy	24b. W	ere autopsy findings
The law require table has been signed as should be completed.												perfe	ormed?	CO	eilable prior to mpletion of cause
Re lay has tge 2													- 10/1 44		death?
	<u> </u>	25. Wes case refer	and to madion										Yes 2 No	11	☐ Yes 2☐ No
f Vital Rec yeician: The law s certificate has b director, page 2 s		examiner?		Hospitel:	Canadian			aC DO	Oth	or		h (Check only			
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Die grand	3	4 Homicide	Gelein	buil	ding, etc. (5	Specify)		-,,,	,			City or To	wn, Stete)		
Division of Vita Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certific, tely filled in by the funeral director, they filled in by the funeral director.		29e. Certifier	N Certifyin	ng Physician: To th	ne best of m	v knowleda	e deeth	occurred e	et the tin	ne, dete e	nd niece	end due to the	ceuse(s) and n	nenner as e	teted
Divisio To the Hospital or Attendivibin 24 hours after death. To the Funeral Director: A completely filled in by the it. Medical Certificati		(Check only one)	2 Medical	Examiner: On the	basis of ex	aminetion e	nd/or inve	estigation,	In my o	pinlon, de	eth occur	red et the time,	dete end plece	, and due to	the cause(s)
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State of Maryland / Department of Health and Mental Hygiene

reportant: if item 27 is marked other than "natural", or items 23s or 23s-1 show a critical marked other traumatic event, the Medical Examiner must be notified at consider. To Be Completed by Funeral Director	4e. Fecility Name (If not in 1807 IF 5. Social Security Number 216-28-0158 Usual Residance of Dece 10a. State MD DC 10e. Street and Number 1807 IF 11. Maritel Status 1 Never Married 2 3 Widowed 4 D (Specify only Elementery/Secondary 12 17. Fether's Name (First, Georgan Suzanne 12 Surial 2 Cren 4 Donetion 5 C	Brook stitution, give Iudson 6. S dent County Prchest Iudson Merried ivorced ecadent's Ed v highest gre- (0-12) Middle, Lest) rge Islationship (7	ks West, estreet end number) Road ex M 2 F 7 ter Rd. 12. Was Decedent Armed Forces? 1 Yes, Give Yeer or Detes: lucation de completed) College (1-4or 5	e (In yrs. last b	wn or Location Cambri 10f. 2	dge Zip Code Zip Code Zip Code Zip No	Hours Min 21613 Hispenic Origin? (Specify:	8. Date of Bi (Month, De Oct. 25	h 4c. County Dorcl th y, Year) 5 1920	9. Birthp Coun Virc	lece (Stete or Fitty) Jinia Od. Inside City I 1 Yes 2		
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mportant: any injury zhce.	4 Donetion 5 C			20b. Place	of Disposition (N	leme of	ce)	Date	20c. Location -	City or To	wn, Stete		
五五元	21. Signeture of Funeral S						1	7-1997	Cambride	re. M	farvland		
五五元	12 Burial 2 Cremetion 3 Removal from Stete Cemetery, cremetory or other piece) Cremetory of other piece Cremetory of												
	D // V L	1			Thoma	s Fur	neral Hom	e PA					
miner	Immediate Cause (Final disease or condition rasulting in death)		a	Due to (or es e	consequence o	f):				4	3 Mor		
physician and streets the bunial-transit	Sequantially list conditions if eny, leeding to immedia cause. Entar Underlying Cause (Diseese or injury	ia \int	b. ————	Due to (or as e	consequenca o	r):			1				
D 8 2	thet initieted events resulting in deeth) Lest		Due to (or es e consequence of):										
# o m	Pert II. Other significant c	onditions co	intributing to death hi	it not resulting	in the underlying	Cause ch	ren in Pert I	23h Did	tobacco use con	tribute to	the course of d		
igned by the attend be detached for use by Physician/			with butting to doubt be	A FIOT TOSUMING	in the underlying	cause giv			Yee 2 No		4 -		
2 should									en eutopsy rmed?	eve	ore autopsy find pilable prior to appletion of caus deeth?		
Com								10	Yes 2 No	1	Yes 2 No		
Be Betor	25. Wes case referred to r exeminer?		H'-					eth (Check only o	ona)				
	1 Yes 2 No		Hospital: 1 Inpatie				4 LI Nursing F		dence 6 Othe)		
funer ion:		Pending	28e. Dete of Injur (Month, De)	Year) 28b.	Time of Injury	28c. injur Wor		28d. Dascribe i	how injury occurre	bed			
al Director: After the in by the funeral control of the funeral cont	3 Suicide 6	invastigation Could not be datermined	28e. Plece of Injubuilding, atc	iry - At homa, fo	erm, straat, facto		Yes 2 No	28f. Location (S City or Tox	Street and Number vn, Stete)	er or Rural	Route Number		
Funer Hely fill	29a. Certifiar (Check only one)	ertifying Phy edical Exami	sician: To the best of iner: On the basis of end menner ste	axaminetion er	a, deeth occurra ad/or Invastigatio	d et tha tin n, in my o	ma, date end place pinion, daath occu	, and due to the rred et tha tima,	ceusa(s) and mar dete end plece, a	nner es ste nd due to	eted. the ceuse(s)		
Mec Mec	29b. Signeture end title of	certifier	0	_	2	9c. Licens			29d. Date signed	(Month, L	Dey, Yeer)		
	Mull	am	Dar			04	13238		3/5	9-	7		
3	30. Neme and eddress of p	erson who co	ompleted cause of de	eth (Itam 23e)	(Type, Print)		lin St		(1			

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 26, 1997 RALPH WALKER 7:00 PM 4a. Facility Name (If not Institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL HOSPITAL COLUMBIA 5. Social Security Number If Under 1 Yaar If Undar 24 Hrs.
Months Days Hours Min. 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) 1**欠** M 2□ F Days 240-42-7549 1-11-1932 NORTH CAROLINA Usual Rasidance of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND ANNE ARUNDEL JESSUP 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2049 HORSESHOE CIRCLE 20794 U.S.A. 12. Was Decedant Ever in U,S Armed Forces? 1.0 5 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - Amarican Indian, TO Yaar or Dates: Black, White, atc. 1 □ Never Marriad 2 □ Marriad 1 ☐ Yes 2 ☑ No 3X Widowed 4 ☐ Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 10 TH STEEL WORKER N/A KAISER ALLUMINUM 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maldan Surname) JOSEPH LUTHER WALKER ELMA WALKER 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) RALPH W. WALKER, JR. (SON) 700 PAMELA RD. GLEN BURNIE, MD. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) VETERANS CEMETERY 3-3-97 CROWNSVILLE, MD. 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility SINGLETON FUNERAL HOME 1 SECOND AVE.S.W. GLEN BURNIE, MD. 21061 asa, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, at List only one cause on each line. Approximata Interval Between Onsat and Death Immediata Causa (Final HEPATIC COMA 24 HOURS disease or condition rasulting in death) ACUTE AND CHRONIC HERATIC FAILURE Saquentially list conditions, if eny, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated evants resulting in death) Last ALCOHOL Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HEART CONGESTIVE 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was en eutopsy performed? 25. Was cese referred to medical axaminer? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident

The lew requires that the death certificate be executed certificate

P.O. Box 68760,

Division of Vital Records,

Attending Physician:

this

After

death.

Hospital or Attendi 24 hours efter death Funeral Director:

To the Hospital of within 24 hours of To the Funeral D completely filled i

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show

items ?

"natural", or item adical Examiner

marked other than

Pages 1 and 2 should be fill ment of Health and Mental Heant: If Itam 27 is marked oth jury or other traumatic even

Department of Important: If any Injury or

Physician /Medical

Examiner

Director

Funeral

Completed by

Be

the Maryland

filed within 72 hours efter death with

21215-0020

Baltimore, Maryland

à Completed Be P

Physician/Medical Examiner filled in by the funeral Medical Certification:

5 Pending Invastigation

6 Could not be determined

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

1 ☐ Yas 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 Suicida

4 Homicide

Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the ceuse(s) end manner stated.

29b. Signature end inte of certifier,

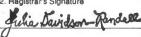
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed ceusa of death (Item 23a) (Type, Print)

MAURER MD 9501 OLD ANNAPOLIS RUAD ELLICOTT CITY MO 21042 31. Date filed (Month, Day, Yaar) 32. Ragistrar's Signature

State Registrar

MAR 0 4 1997



DHMH 16 Rev 6/95

March State of the
State of Maryland / Department of Health and Mental Hygiene 97 09062

						,	C	ertifica	ate of	Death		Re	g. No.	, 1	00002
П	Dhusia		1. Decedant's Nama	(First, Middla, La	est)							ita of Death			3. Tima of Death
J	Physic /Med		JOHN G	EORGE W	VLASIC							onth ListCU	Dey L	Yaar	8:00 am
	Exami		4a. Facility Name (If r	not institution, giv	e street and nur	nbar)				4b. City, Town,			4c. County	of Death	
1			115 VERN	ON AVENU	UE					GLEN B	URNIE		ANNE	ARUN	DEL CO.
П	Funeral		5. Social Sacurity Nur			7. Age (In yı	s. last birthd	(ay) If Und Month	ar 1 Yaar s Days		Hrs. 8. De	ta of Birth onth, Day,			place (Stata or Foreign
ŀ	Director		216-01-44	<i></i>	10XM 2□ F	78	Yrs		Days	110013		-23-19			YLAND
	8 8		Usual Rasidanca of D	ecadant 10b. County		100 (City, Town o	a Lagation							
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Division	or Attendate death	Certification:	4 Homicida	datamined	28a. Place	of Injury - At I g, atc. (Spec	noma, farm, ify)	street, facto	ry, offica			pation (Street y or Town, S		er or Rura	Routa Number,
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	To the Hospital within 24 hours a To the Funeral Completely filled	edical	Consecutivity 2	Certifying Phy Medical Exam	nner: On the bas	sis of axamin	owledga, da ation end/or	ath occurre- invastigatio	d at tha tin	ma, data end ple pinion, deeth o	ce, and due	to the cause time, data	sa(s) and ma	nnar as st	ated. the causa(s)
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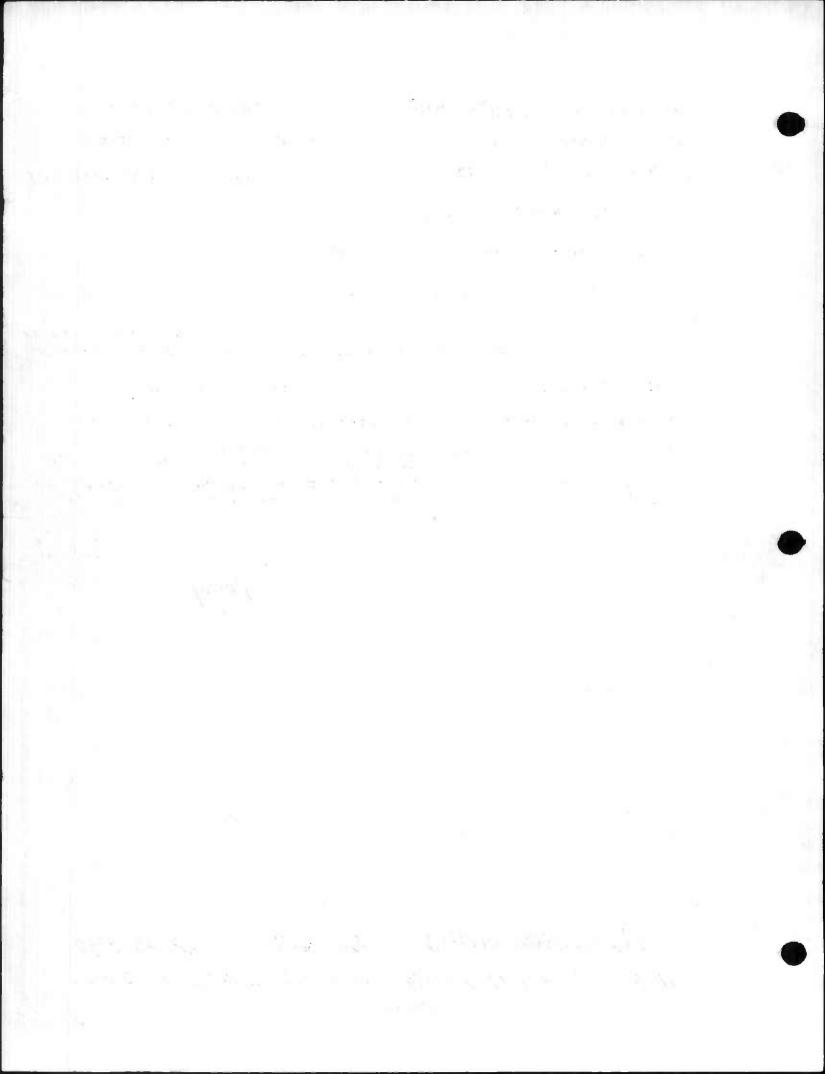
Fig. 1. The second of the seco

State of Maryland / Department of Health and Mental Hygiene

08063 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 28, 1997 **Physician** ZAPPONE MICHALZ 4:11 pm February /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 780 Matchpoint Drive Anne Arundel Arnold 5. Social Security Number if Under 1 Yeer 6. Sex 7. Age (In yrs. lest birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Dete of Birth (Month, Dey, Yeer) Months Deys Min. 1 M 2 □ F Hours 191-12-8828 73 Yrs. Director July8, 1923 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits must be notified at Anne Arundel MD Director Arnold 1 ☐ Yes 2 No di El 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? b 780 Matchpoint Drive 21012 Herns 23a USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates: WWII 11. Marital Status 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Americen Indian. the Medical Examiner Biack, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☑ Married 21215-0020 b 1 ☐ Yes 2 No White λq Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Anne Arundel County if Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5 + Pupil Personnel Advisor Board of Education Saltimore, Maryland traumatic event. 17. Father's Neme (First, Middle, Last) . Pages 1 and 2 should be fill tment of Health and Mental H lant: If Rem 27 is marked off 18. Mother's Name (First, Middle, Maiden Sumeme) Be Paul Zappone 20 Julia Pallone 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health, Important: If Item 27 It any injury or other tra Rosemary Zappone/wife 780 Matchpoint Dr., Arnold, MD 21012 20b. Plece of Disposition (Name of cametery, cremetory or other plece)
Maryland Veterans 20a. Method of Disposition Date 20c. Location - City or Town, State Mar 1997 1 Burial 2 □ Cremation 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD - Crownsville Home 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral 495 GovRitchie Hwy., Severna Park, MD21146 23a. Part . Enter the disease, or complications that council the shock, or heart failure. List only one ceuse on the line the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician /Medical Immediete Cause (Final pheumonia diseese or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner Supra nuclear The law requires that the deeth certificate be executed Sequentially list conditions, if any, leeding to Immediate ceuse. Enter Underlying Cause (Olseese or injury that Initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, attending physician for use as the burie Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown signed t ğ Completed 24e. Was an eutopsy performed? 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? certificate hes b irector, page 2 s 1 Yes No 1 Yes or Attending Physician: director Be 25. Wes cese referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home Residenca 8 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Neturei 5 Pending investigation deeth 1 Yes 2 No s after deeth I Director: A of in by the fo 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homleide To the Hospital o within 24 hours af To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner steted. Medicai (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) women walsh mr 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)
THOMASWAUSH MD 277 Feminsula Farm Read ARNOW MOZIO12 32. Registrar's Signeture 31. Date filed (Month, Day, Year) State Registrar MAR 06 1997

DHMH 16 Rev 6/95



e	of	Maryland /	Department	of	Health	and	Mental	Hygiene
			Certificate	of	Death	7		

Physician	
/Medical	
Examiner	ı

1. Decedent's Name (First, Middle, Last)

2. Dete of Death

Yes 2 No

Approximete Intervel Between Onset end Deeth

Funerai Director

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

ds. P.O. Box 68760.

Division of To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After

MARCH 12, 1997 THOMAS J. ANDERSON JR. 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death SECOUR HOSPITAL BALTIMORE 5. Social Security Number If Under 1 Yeer 7. Age (In vrs. lest birthday) Birthplece (State or Foreign Country) Deys 100M 201F Months Hours 217-22-9021 Yrs. Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at BALTIMORE Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 11. Merital Stetus 12. Was Decedent Ever in U.S. Armed Forces? 2 Married 1 Never Married 1 ☐ Yes 2 D No If Yes, Give Yeer or Dates: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Num 20b. Pleca of D 1 Bunal 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion / 5 ☐ Other (Specify) the disease, or complications that caused the death. Do not enter the mode of dying, earl failure. List only one cause on each line. Immediete Ceuse (Final diseese or condition resulting in death) o. Hypertensive Alheroscherotic Cardiovascular Due to (or es e consequence of): Examiner sician and burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequença of) attending physician lor use as the buria Physician/Medicai Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown for lipoma removal from neck þ 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 12 Yes 2 □ No 1 Yes 2 No 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 🂢 ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2

25. Wes case referred to medical examiner?
1 △ Yes 2 □ No 27. Menner of Deeth 1 Neturel

2 ☐ Accident

3 ☐ Suicide

4 Homicide

5 Pending investigation 6 Could not be determined

28e. Dete of Injury (Month, Day Year)

28b. Time of 28c. Injury et Work?

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how Injury occurred

1 Cartifying Phyelcian: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and menner as stated.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end placa, end due to the ceuse(s) end menner stated. (Check only one) 29b. Signature end title of certifier

29c. License number

1 Yes 2 No

29d. Date signed (Month, Dey, Yeer)

O.C.M.E.

MARCH 13, 1997

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

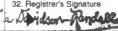
Stephen S.
31. Dete filed (Month, Dey, Year) adrntz, MO111 Penn Street, Baltimore, Maryland 21201

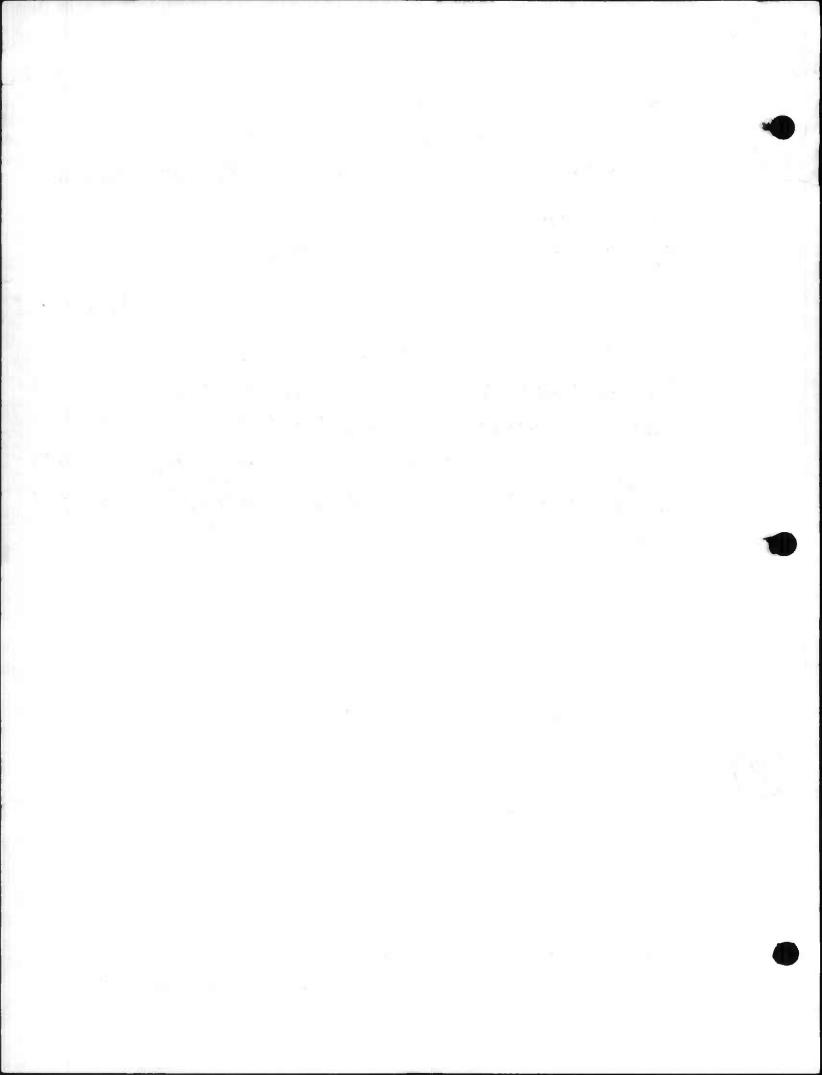
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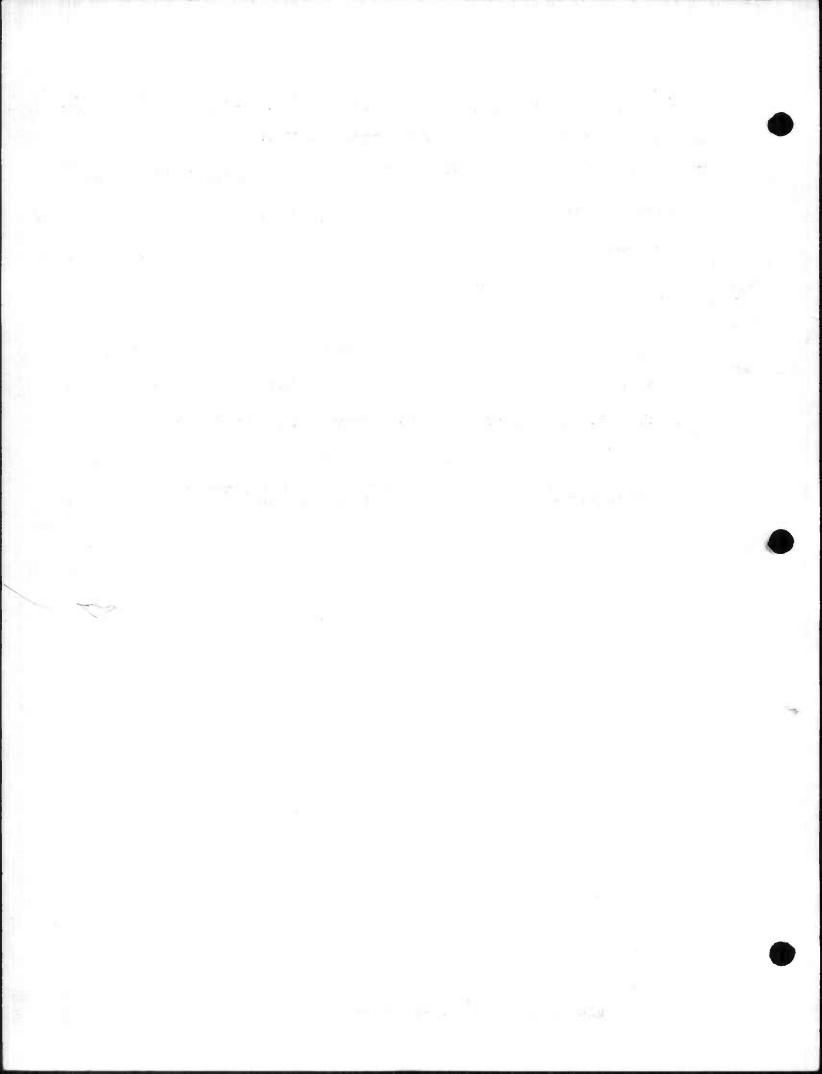


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Deeth Day **Physician** UHNITA Marci /Medical 4e. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Nursing and Rehabilitation Center Bel Air Harford 7. Age (In yrs. last birthday) If Undar 1 Yeer | If Undar 24 Hrs. 5. Social Security Number 6 Say Birthplace (Steta or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Days 1 □ M 2X F 77 217 01 5017 Director Dec. 25,1918 Ohio Usuei Residance of Dacedent 10a State 10h Counts 10c. City, Town or Location 10d. Insida City Limits Maryland Harford Bel Air 1 Yes XXNo Director r 28a-f s 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Sunflower Dr. 21014 United States 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas ②CXNo If Yes, Give Year or Dates: 1 ☐ Yes 2√☐ No Specify: þ 3 MWidowed 4 □ Divorced Specify: White Baltimore, Maryland 21215-06 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry the Med Eiementery/Secondery (0-12) Coilega (1-4or 5+) Homemaker Domestic Pages 1 and 2 should be filed ient of Health and Mental Hygi nt: If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) (Unknown) Kathary Ruth Lucille. Clark 19e. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Sarah L. Ford / daughter 422 Underwood Cir., Bel Air, MD 20a. Method of Disposition 20b. Place of Disposition (Nema of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 1 ☐ Burlai 2 ☑ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Department of Important: If any Injury or Injury or Green Mount Crematory 3/17/97 Baltimore, MD 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Pert1. Enfar the diseesa, or complications that causad tha daath. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaese or condition resulting in deeth) Examiner Dua to (or as a consequence of) Examiner siclan and burial-transit Sequentially list conditions, if any, leeding to immediate cause. Entar Underlying Couse (Diseese or Injury that Initiated events rasulting In death) Lest Due to (or es e consequence of): physician at the burial Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) attending pt ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown þ ar fallycardia should | 24b. Were autopsy findings available prior to completion of causa of death? 24a. Wes en autopsy performed? Completed has certificate 1 ☐ Yes 2 ☐ No 25. Wes case rafarred to medical Be 28. Placa of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Mepper of Deeth 28e. Deta of Injury (Month, Day Year) 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? After Naturel 5 Pending investigation death. 1 Yes 2 No Hospital or Attendi 24 hours after death Funeral Director: A 2 Accident 6 Could not be datarmined 3 Suicide 28e. Plece of Injury - At home, ferm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledga, death occurred et the time, deta end place, and dua to tha cause(s) end mennar as stated.

2 Medical Examiner: On the basis of axamination and/or investigetion, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29e. Certifier Medical 29b. Signature end title of certifier 29d. Dete signed (Month, Day, Year) 30. Name and address of person completed cause of deeth (Itam 23e) (Type, Print) Ablu 31. Dete flied (Month, Dey, Year) 32. Registrar's Signetura State MAR 18 199 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death ITEM: 5 perFH G-746 4-3-97 eoh 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Tima of Death **Physician** March WINIFRED ALLGEIER 1997 2:45 P.M. /Medical 4a. Fecility Name (If not institution, give streat and number) ST. JOSEPH NURSING HOME 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** CATONSVILLE BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year 11-26-1904 5. Social Sacurity Numba 7. Aga (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months 1□M 25 F 64-09-8711 92 Vre Director WI 17-50-8976 Usual Residence of Dacadant the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Medical Examiner must be notified at MD Director BALTIMORE CATONSVILLE 1 Yas ZINO 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 5 1222 TUGWELL AVENUE 21228 U.S.A. Herns 23s Funeral 12. Was Dacedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Yaar or Detes: 11. Maritel Status Was Decedant of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) Race - Amarican Indien, Bleck, Whita, atc. Peges 1 and 2 should be filed within 72 hours efter and of Health and Mental Hydine. Intell Hitman 27 is marked other than "natural", or the lay or other traumatic event, the Moulant Example. 1 Never Married 2 Marriad Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No þ Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Be LAWRENCE FRANEY CATHERINE McCORMICK 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda) DANIEL ALLGEIER (SON) 111 FOREST DRIVE CATONSVILLE MD 21228 20e. Mathod of Disposition 20b. Place of Disposition (Nama of camatery, cramatory or other place) 20c. Location - City or Town, Stete 1 Burial 2 Cramation 3 Ramoval from State permit. Pege Depertment of Important: If any injury or once. 4 ☐ Donation 5 ☐ Othar (Specify) WOODLAWN CEMETERY MAR.18,1997 WOODLAWN MD 21. Signature of Funaral Service Licensas WITZKE FUNERAL HOME OF CATONSVILLE, INC. 1630 EDMONDSON AVENUE CATONSVILLE MD 21228 23a. Part 1. Enter the disease, or contributed to have that caused the deeth. Do not antar the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intarval Between Onset and Deeth **Physician** Ley Disease Immediata Causa (Final disaase or condition rasulting in daath) /Medical lav. Examine Dua to (or as a consequence of) Examiner physician and s the buriel-transit vires that the death certificate be executed Sequentially list conditions, if any, laading to Immadiata causa. Entar Undarlying Causa (Diseasa or Injury that initiated avents resulting in daath) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai Dua to (or as a consequanca of): for use as been signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown ords, Be Completed by 24b. Wara autopsy findings evalleble prior to completion of causa of death? 24e. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No 25. Wes casa rafarred to medical axaminar? 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 쿻 28a. Data of Injury (Month, Day Year) 27. Manger of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Naturai 5 Pending 1 Tas 2 No invastigation 2 Accidant sher death 6 Could not ba detarminad 3 Suicida 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 4 - Homicide

Division of Attending 6 within 24 hours a To the Funeral C å

Registrar

Medicai

31. Data flied (Month, Day, Year) State

29b. Signature and title of certifier

29a, Certifier (Check only one)

u

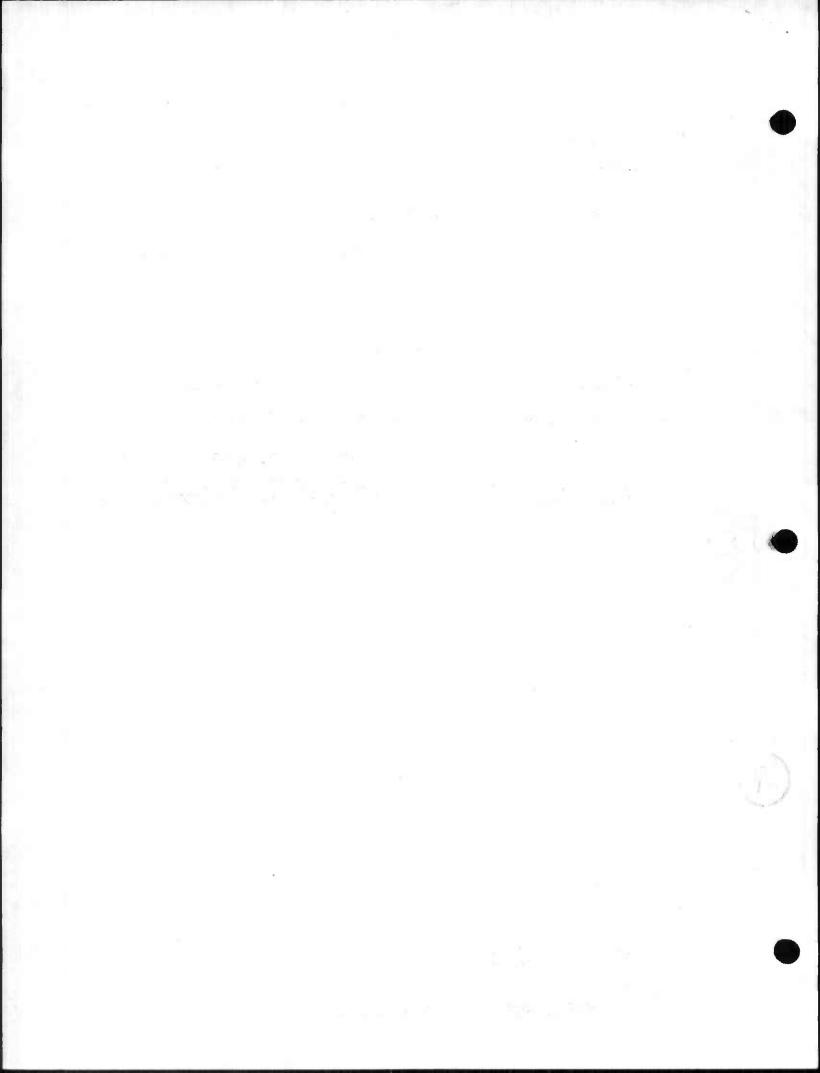
29c. Licensa number

12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year)

gandio 30. Nama and oddress of person who completed cause of death (Itam 23a) (Type, Print)

> 1222 TUGWELL AVENUE CATONSVILLE MD 21228

32. Registrar's Signatura MAR 1 8 1997 Julia Davidson



State of Maryland / Department of Health and Mental Hygiene

				State of Maryla	-	tificate o			Reg. No.	97	08067
	Physic /Medi		Decedent's Name (First, Middle, ELIZA		ARNOLD			2. Date of De Month March	Day	Year 97	3. Time of Death 8:36 AM
	Examile Funeral Director	ner	213-74-3013	t Home	s. last birthday) Yrs.	If Under 1 Ye Months Day	Sykesvi	s. 8. Date of Bir	Car th by, Year)	9. Birthple	ace (State or Foreign ly) yland
	Varyland f show	or	Usual Residence of Decedent 10a. State 10b. County MD Carro		City, Town or Lo					10	od. fnside City Limits
	h with the h	al Director	10e. Street and Number 1442 Buckhorn R	d.		10f. Zip Code	21784		10g. Citizen of V		ny?
020	72 hours efter deeth with the Maryland natural', or items 23s or 28s-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces?	1	Was Decedent of	f Hispanic Origin? (uban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14. Rac	e - Americe ck, White, e	
Maryland 21215-0020	within ene. then	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education rede complated) College (1-4or 5+)	(Give life. L	lent's Usual Occ kind of work doi DO NOT use ret	ne during most of wo ired)	orking	16b. Kind of Bu	usiness/Ind	
land?	tal Hyg d othe event,	To Be C	17. Father's Name (First, Middle, Late James J. Purse	•	110		18. Mother's Na	ame (First, Middle,	, Melden Sumen	-	
, Mary	and 2 should the little and Men and Men 27 is marked ther traumatic		19a. Informant's Name/Relationship Susan S. Dougla	s	2500	3 Angel	eet and Number or F La Ct., Sy			Stete, Zip (Code)
Baltimore,	Pages nent of uny or o		20a. Method of Disposition 1 Durial 2 Cremation 3 4 Donation 5 Other (Special Control of Control	Garage Garage Garage	Place of Dispo- cemetery, crem ardens			Date 3/11/97	20c. Location - Baltin		
Bal	permit. Departi Importu any inji		21. Signature of Funeral Service Lio	Otto De	AL		FUNERAL ord Rd.			21214	
, iš	Physician /Medical		Immediate Cause (Final								Approximata Intervel Between Onset and Death
	Examiner	ner	disease or condition resulting in death)	a. PRIMAR Dua to	(or as a conseq	uence of):	Du ANNA	e Disco	As	1	> 34RS
,09785	icate be executed physician and s the buriel-transit	al Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Entar Underlying Cause (Disease or Injury	Due to	(or as a conseq	uance of):	iaco e e e e e e e e e e e e e e e e e e e				
Box 687	ding se as	an/Medical	that Initiated evants resulting in death) Last	Due to	(or es e consequ	uence of):			1		
, P.O. E	hat the o	y Physician/M	Part II. Other significant conditions	contributing to death but not re	esulting in the ur	nderlying causa	givan In Part I.		tobacco use co		the cause of death?
ecords	Then sign	Completed by						24a. Was	an autopsy ormed?	eva	ra autopsy findings ilable prior to apletion of cause laath?
VIII	Physician: this cartificale ral director, pega	Be	25. Was cese raferred to medical examiner?	Hospital:			Whose .	ath (Check only	one)		Yes 2□ No
5	ing Phys n. After this funeral di	ation: To	1 Yes 2 100 27. Manner of Death 1 Matural 5 Panding 2 Accident investigati	28a. Date of Injury (Month, Day Year)	28b. Time of injury	28c. In	4 Nursing	Home 5 Resi	dence 6 Oth how injury occur)
Division	Per P	Certification:	3 Suicide 6 Could not datermine	d 28e. Place of Injury - At building, etc. (Spec	cify)			City or To			
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	Medical	one) 2 Medical Exe	thyalcian: To tha best of my kr aminer: On the basis of examined end manner statad.	nowledga, daath nation and/or inv	restigation, in m	y opinion, death occ	a, and dua to the curred at tha tima,	data and place.	and due to	the cause(s)
)	1 2 2 2		29th. Signature and title of certifier	esus		0.	2080 G		3/7/	97	ray, Tear)
	P		30. Name and address of person who ATRICK A - TU 31. Date filed (Month, Dey, Year)	complated cause of death (Its	am 23a) (Type, I	LIBERTY	1 RD	ELDORSI	BURG M	0	21784
	Sta Registr	-	MAR 1 8 199	7 Super Davide	on-Aanda	82.					

State of Maryland / Department of Health and Mental Hygiene 08068 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** RUTH ARNOLD 13, 7.35 PM MARCH 1997 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore City N/A | If Under 24 Hrs. | 8. Date of Birth (Mogth, Day, Year) | 9. Birthplace (Stele or Foreign Country) | March 19, 1910 | Washington, D.C. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2 F Months Yrs. 216-56-6329 86 Director Usual Residence of Decedent the Merylend 10a. State 10b. County 10c. City. Town or Location 7 is marked other then "natural", or Items 23s or 28s-f show traumstic event, the Modical Exerciser must be notified at 10d. Inside City Limits 1X Yes 2 □ No Directo Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4217 Stanwood Avenue 21206 U.S.A. death Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours efter 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: by Specify: White 3 Widowed 4 □ Divorced "natural". Completed 15. Decadent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done di life. DO NOT use retired) during most of working Pages 1 end 2 should be filed within nent of Health end Mentel Hygiene. nnt: If itam 27 is marked othar than "I ary or other traumatic event, the Health or other traumatic event, the Health or the traumatic event, the Health or the traumatic event, the Health or the traumatic event, the Health or the traumatic event, the Health or the traumatic event, the Health or the traumatic event, the Health or the traumatic event, the Health or the traumatic event, the Health or the traumatic event, the Health or the traumatic event, the Health or the traumatic event, the Health or the traumatic event, the traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Jeremiah Knight Roger Katie Louise Snyder 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn A. Block/Daughter 1413 Pleasant Valley Drive, Catonsville, Md. 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlai 2 □ Cremation 3 □ Removel from State permit. Page Depertment of Important: If any Injury or Lake View Memorial Park 3/17/97 Sykesville, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name and Address of Facility R Thomas John C. Miller, Inc. uanita 6415 Belair Road, Baltimore, Maryland 21206 23a. Pet 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick or heert feilure. List only one ceuse on each line. Approximate Intervel Between **Physician** /Medical Immediate Ceuse (Final SEPTIC 1 DAY diseese or condition resulting in death) SHOCK Examiner Due to (or as a consequence of). PNEUMONIA I DAY be executed buriel-transit Exami Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequenca of) physicien s the buriel Box 68760 Physician/Medicai Due to (or as a consequence of) 80 ettending USB for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. the 23b. Did tobacco use contribute to the cause of death? 2 1 | Yes 2 | No 3 | Probably 4 OrUnknown signed b by 24b. Were autopsy findings avaitable prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed peen page 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No certificate Physician: Be 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Hospitet: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this Bra 27. Manner of Deeth 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Coutd not be determined 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 24 3 To the within To the 29b. Signature and titte of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. MARCH 13, 1997 110582 Harous 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) ANN MECHERIKUNNEL 5601, LOCH RAVEN BLUD., BALTO., MD - 21239 31. Date filed (Month, Dey, Year)

State Registrar

MAR 18 1997

. 32. Registrar's Signature wie Vertason A

State of Maryland / Department of Health and Mental Hygiene Q 7

						Cer	tificate	of D	eath		Reg	. No.	וכ	0000;
	,	1. Decedent's Nem	e (First, Middle, La	st)						2. Dete d	f Deeth			3. Time of Death
Physi /Med		Eva M. B	ond							Marc		Dey 199	Yeer 7	11:11am
Exam		4e. Fecllity Neme (I		e street end num	ber)			4b.	City, Town,	or Location of C		4c. Count		11.1100
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Funera	ıl	5. Sociel Security N	lumber 6. S	Sex 7	. Age (In yrs. last		If Under 1	Year I	f Under 24 h	irs. 8. Dete o	f Birth		1	piece (State or Fore
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th th	Director	10e. Street end Nur	mber				10f. Zip Co	ode			10g	. Citizen of	Whet Cou	ntry?
th wi	<u>a</u>	1209 621	nd STREET				21	237				USA		
dea	Funeral	11. Maritel Status		12. Wes Deced	ient Ever in U,S.	13. V	Vas Deceden	t of Hisp	enic Origin?	(Specify Yes o	r No-	14. Re		can Indien,
in 72 hours after death with the Maryland "To hours after death with the Maryland "naturel", or items 23s or 28s-f show edical Examiner must be notified at	þ	1 Never Marri	ed 2 Married 4 Divorced	1 Tes 2	∑ No		Yes 2			ierto Rican, etc)	Specif	ock, White, fy: [/	etc. VHITE
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d 2 should be ith and Mental if is marked or traumatic even		19e. Informent's Ne	me/Relationship (Type, Print)	1	9b. Meilin	g Address (S	itreet end	Number or	Rural Route N	ımber, C	ity or Town	, Stete, Zip	Code)
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s 1 an of Heat Item 2 other		20a. Method of Disp	oosition		0.0000	of Dispos	sition (Neme	of	11.	Dete		c. Location		own, Stete
Page ent c			☐ Cremetion 3 ☐ 5 ☐ Other (Specification 2)		ate		OF FA			2/10/0	7 0	AT TIME	ים מתי	170
permit. Pages 1 ar Department of Hea Important: If Item 2 any Injury or other	à	21. Signature of Fu			Un.		Neme end A		of Fecility	3/19/9				
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		23e. Pert1. Enter the shock, or heer	t feilure. List only	one cause on ear	line.	o not ente	er the mode o	r ayıng, s	such es cero	liac or respireto	ry errest	•		Approximete Interval Between
Physiciar /Medica		Immediete Ceuse (Final	^ .					. ^	\			1	Onset and Deeth
Examine	_	diseese or condition resulting in death)	n	e. Hote	rioscle	rome	c (01	400	say (uscila	1779	ene.	1	453
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0 0 2	Physician	Pert II. Other signifi	cant conditions of	ontributing to dea	th but not resulting	in the un	derlying caus	e given	n Pert I.	23b.	Did toba	cco use co	ntribute to	the cause of deat
that the da ed by the detached	듄	Trevious	Dyocar	deal .	Inface	icon	,			-	Yes	2□ No	3 Pro	bably 4 Unkno
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or Attending Physiciant. T after death. Director: After this certifical i in by the funeral director, pi	Be (25. Wes case referr	ed to medical					2	6. Piece of D	Deeth (Check o	nhy one)			
Physician; this certific ral director,	2	exeminer?	No	Hospitel: 1 Inp	patient 2 ER/	Outpetient	3□ DOA	Other:		Home 5 IF		e 6 DOth	er (Specif	v)
the state of the s		27. Manner of Deeth		28e. Dete of (Month,		. Time of		Injury et Work?	,			Injury occur		,,
Attending or death. ector: After by the fune	Certification:	1 Neturel 2 Accident	5 Pending investigation		Dey real)	Injury	М		2 🗆 No					
Atta rr des ecto by th	ill o	3 Suicide	6 Could not be determined	28e. Placa of	Injury - At home, , etc. (Specify)	ferm, stre	et, fectory, of	fice					ber or Rura	Il Route Number,
5 등 등 등	F.	4 LI Homicide		building	, etc. (Specify)					City or	Town, S	State)		
To the Hospital or Attani within 24 hours after deal To the Funeral Directors completely illed in by the	edical (29e. Certifier (Check only one)	12 Certifying Phy 2 Medical Exam	/sician: To the be iner: On the basi end menne	is of exemination (ge, deeth and/or inve	occurred et the estigetion, in a	ne time, my opini	dete end ple on, death oc	ce, end due to curred et the til	the ceus	e(s) end ma end plece,	anner as si and due to	leted. the cause(s)
To the transport of the	ž	29b. Signeture end t	itle of certifies				29c. Li	cense nu	ımber		29d.	Date signe	d (Month,	Day, Year)
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./		30. Name end eddre												
		Dr. Micha	ael Schwa		Hammonds istrar's Signature	s Lan	e 2122	25						
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	a.c	1818	1997	"a Diay	dian-hande									

DHMH 16 Rev 6/95

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BALTIMORE, MARYLAND 21215-002

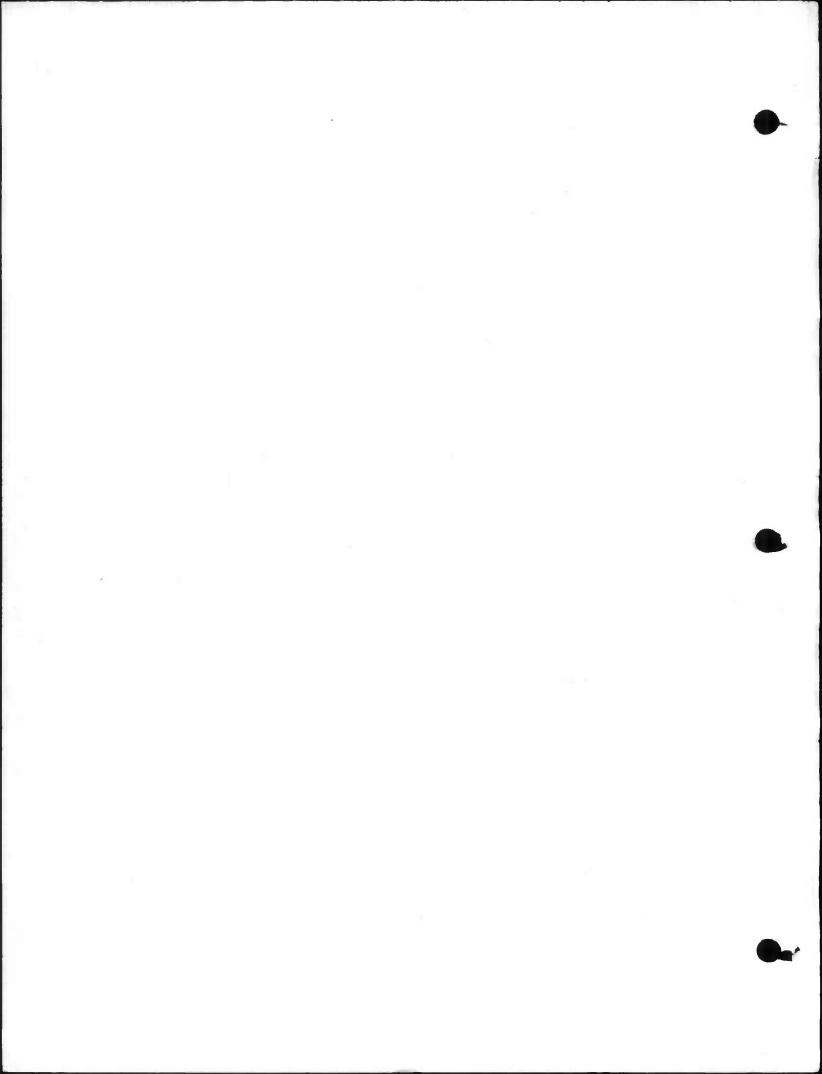
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		C	ERTIF	ICATE	OF	DEATH		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) MARGARET A.				RF	R O W	N	2. DATE	OF DEATH	1 0	9 7	3. TIME OF OEATH 12:15 P M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le:			-		-		1 3		
	212-05-1240	1 M 2 XF	9.5	YRS.	MONTHS I	DAYS	IF UNDER 24 HRS. HOURS MIN.	Sep	of Birth h, Day, Year) t 22	190	Countr	ryland
	9e. FACILITY NAME (If not institution, give at	treet and number)			9b, CITY, T	OWN O	R LOCATION OF D	EATH		9c. COU	NTY OF D	
FUNERAL DIRECTOR	WESLEYAN HOME				DENT	ON.	MD.			CARC	DLIN	E CO.
E I	10a. STATE 10b. COUNTY	1		10c, CIT	, TOWN OR	LOCAT	ION					10d. INSIDE CITY LIMITS?
9		n/a		Ba	ltim	_						1 X YES 2 NO
ERAI	100. STREET AND NUMBER 916 William S	treet				101.	21230			10g. CITI		VHAT COUNTRY?
3	11. MARITAL STATUS	12 WAS DECEDENT	EVER IN U.S. AF	RMED	13, WA	S DEC	ENDENT OF HISPA	NIC ORIGIN	17 (Specify Yes			- American Indian
BY F	1 Never Merried 2 Merried 3 XWidowed 4 Divorced	FORCES? 1	YES 2 X	NO	11.3	yes, spe	2 NO Specif	en, Puerto	Rican, etc.)			- American Indian, White, atc. W: White
뎶	15. DECEDENT'S EDUC (Specify only highest grade		(6	live kind of v	USUAL OCC	UPATIO	N st of working	166	. KIND OF BUS	SINESS/IND	USTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)) <u> </u>	y Ac	e retired.) COUN	tai	nt		C & P			
8	17. FATHER'S NAME (First, Middle, Lest)						18. MOTHER'S NA	ME (First.	Middle Maiden	Sumama)		
BE C	John F. Plack						Annie					
2	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS (S	Street a	nd Number or Rural	Route Num	ber, City or Tow	n, State, Zip	Code)	
F	Louis H. Brown	n (Son)	1	507	Kirk	WO	od Road	Ba	ltimo	re, N	1d.2	1207
	20s. METHOD OF DISPOSITION SO Burlet 2 Commetton 3 Remo	oval from State	20b. PLACE cemetery, cre	and DATE of	her place)	ON (Na	onal 20	Mag	E 20c. LO	CATION —	City or To	wn, Stata
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	Dare	THIOT	22. NA	ME AN	D ADDRESS OF FA	CILITY				
	1 temala	Med	>									uth Balto. Md.21230
	23. PART I. Enter the diseases, or o shock, or heart failure.	omplications that	caused the de	eath. Do n	ot enter th	те то	de of dyling, suc	ch aa can	dlac or respi	ratory arr	est,	Approximate
	MANAGOLATE CALLOG (EL)				4							Interval Batween Onset and Death
	disease or condition resulting in death)	Cou	rgES1	Sure	he	en	- + Fa	, L.	æ			11 week
		DUE TO (OR AS A CONSE	OUENCE OF	7):			-				
Z.	Sequentially list conditions,	DUE TO (alvul	an	has	~	t d	rec	ase			years
Ĕ	if any, landing to immediata cause. Enter UNDERLYING	DUE TO (OR AS A CONSE	OUENCE OF	7:							
2	CAUSE (Disease or Injury	c. DUE TO	OR AS A CONSE	OUENOE OF	D.							
CERTIFICATION	that initiated events reaulting in death) LAST	DOE TO (OH AS A CONSE	OUENCE OF):							
B		d										<u> </u>
	PART II. Other aignificant condition	a contributing to	death but not	rasulting i	n the unde	erlyIng	cause given in	Part I.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS
EDICAL	ofteoper	051/					_	_	1 TYES 2			AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	dehydrah											1 TYES 2 NO
z												~
ĕ S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:				26. PL	ACE OF DEATH (Ch	neck only or	ne)			
Š	1 TYES 2 DONO	1 Inpatiant 2	ER/Outpetient 3	DOA	OTHER:	g Home	5 - Residence	6 🗆 Othe	r (Specify)			
Y PHYSICIAN: M	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF (Month, Da		28b. TIM	URY	8c. INJI	JRY AT RK? ES 2 NO	28d. DE	SCRIBE HOW I	NJURY OC	CURED	
B	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF	INJURY — At he	oma, farm, a				281. LOC	ATION (Street a	and Number	or Rural F	loute Number,
COMPLETED	4 Homicide determined	building, e	etc. (Specify)					City	or Town, State)			
MPL		CIAN: To the best of I										
g I	2 MEDICAL EXAMINE	R: On the beals of ex	emination and/or	investigatio	n, in my opie	nion, di	eath occured at the	Ilme, date	end place, an	d dua lo lh	e cause(a) and manner as stated,
BE (296. SIGNATURE AND TITLE OF CERTIFIER						29c. LICENSE NU		0			(Month, Day, Year)
2			ا هسی				033	76	8	> /C	100	17, 1997
	30. NAME AND ADDRESS OF PERSON WHO					0	ME	4.6.5				
	JAMES E. CORWI 31. DATE FILEO (Month, Day, Year)		BOX 6		DENT	UN	, MD 2	162	9			
	MAR 1.8 1997	SZ. HEGISTRAF	Signatures	Pande	2							
	II I I I I I I I I I I I I I I I I I I	0			-	-						



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month BIACIL oRence RISCILLA MARCH 1997 15 0830 /Medical Balt Move Board Birth (Month, Dey, Year)

Adonths Deys Hours Min.

Adonths Deys Hours Min. 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HOSPHAL Hynes 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□ M 200 F 219-38-6836 Yrs. Director Usual Residence of Decedent the Meryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Battimore Md 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? death with 4808 Carmine 21207 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Detes: 7 is marked other than "natural", or itsms traumatic event, the Medical Examiner m Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Depertment of Health end Mental Hygiene. Important: If Item 27 Is marked other than "natural", or its 1 ☐ Never Merried 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No þ Specify: Black 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Beauty Salon Elementary/Secondary (0-12) College (1-4or 5+) eautician 12th grave 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) erbert Horence 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 4808 Balto, Md 21207 Horence other 20b. Plece of Disposition (Name of carnetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State ò 1 Burial 2 Cremetion 3 Removel from State 4 □ Donetion 5 □ Other (Specify) landallstown, rd 21. Signature of Funerel Service Licensee l ade Wabash 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel rneumoni A diseese or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner Sclerosis attending physician and for use es the bunel-transit Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest law requires that the death certificate be exec Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of): Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yas 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings svellable prior fo completion of cause of death? Completed 24e. Wes en eutopsy performed? 250 No 1 ☐ Yes 2 No 25. Wes cese referred to medical exeminer? Be 28. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 2 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: Division 1 Neturel 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after deat Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) B 4 Homicide To the Hospital o within 24 hours at To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

2 Madical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted. edicai 29a. Certifier (Check only one)

29c. License number

P10873

BUADI, STAGNES HOSPITAL, 900 CATON AVENUE, BALTIMORE, MO, 21229

MD

32. Registral Standard Rondon

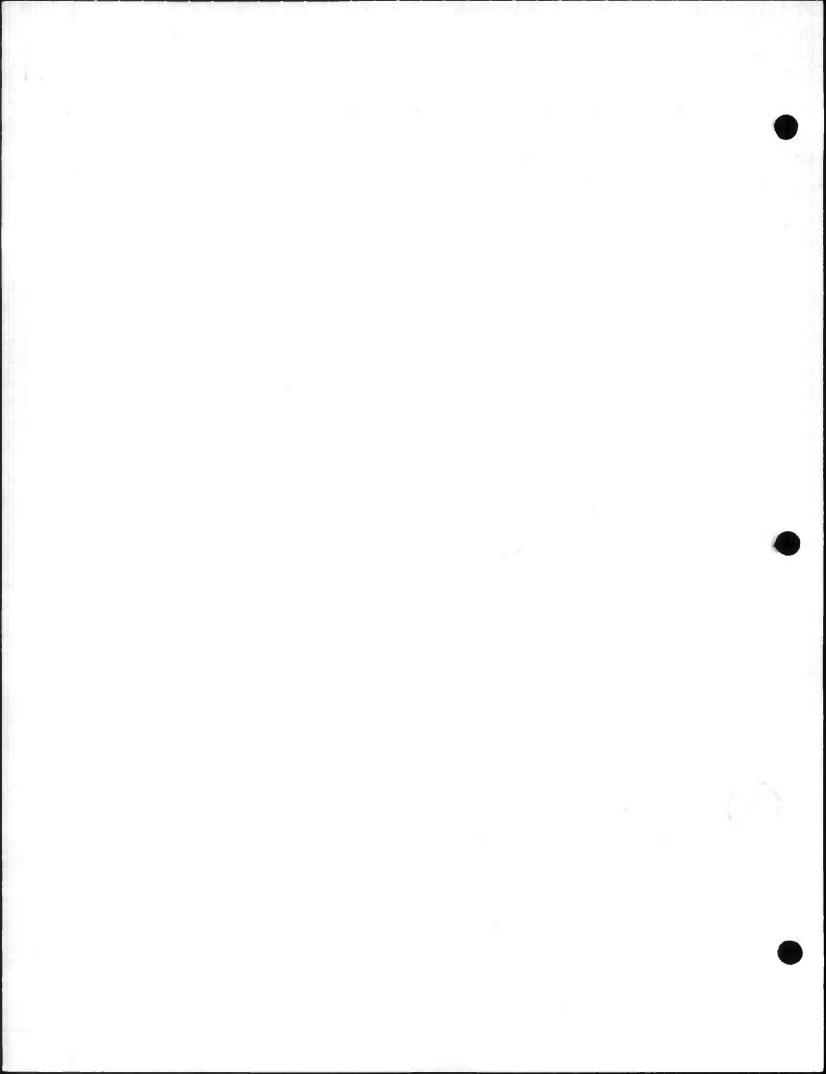
30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

29d. Dete signed (Month, Dey, Yeer)

State Registrar

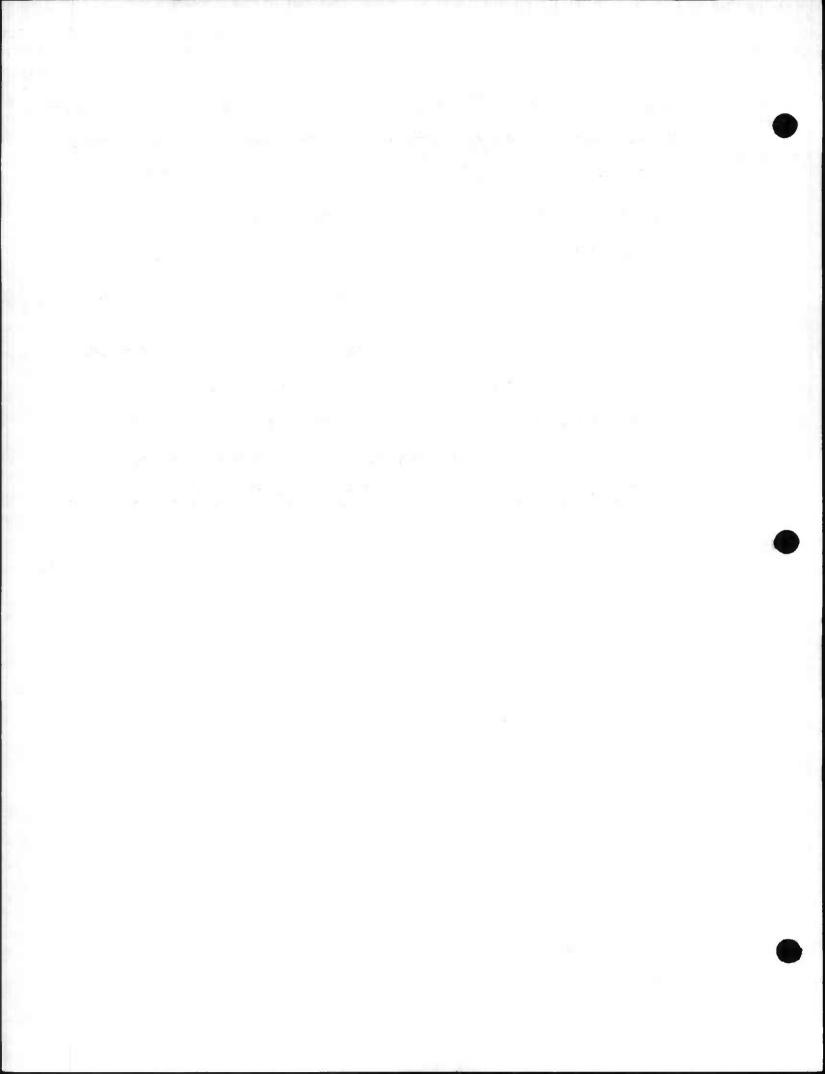
29b. Signeture end title of certifier

FRANCIS



State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, Middle, La	et)		C	Certifica			2. Date of De	Reg. No.	7 08072
Physici	an	Mary Esth		T	3radb	urn			Month	Day	Year
/Medic		4a. Facility Name (If not Institution, give			or aut	Jul II		4h City Town o	March or Location of Deat		997 12:40 AM
Examin	ier	Genesis Hammonds			Cent	er		Baltim			
S		Social Security Number 6. 3		ge (In yrs.			ar 1 Yaar	If Under 24 H			Arundel
Funeral Director			□ M 2[X]F	92	Yn	Months	Days	Hours Mi		r 7,1904	9. Birthplace (State or Foreign Country) maryland
CI		10a. State 10b. County	34	10c. Cit	ly, Town o	r Location					10d. Inside City Limits
ALIE	E S	Maryland Anne A	rundel				G	len Bur	nie		1 ☐ Yes 2 No
3/4 al	E	10e. Street end Number				10f. Z	ip Coda			10g. Citizen of WI	nat Country?
	E .	508 Kent Circle						21060		United	States
8 19	Funer	11. Marital Status	12. Was Decedent	Ever in U	,S.	13. Was Dec	edent of H	Ilspanic Origin?	(Specify Yas or No orto Rican, atc.)		- Americen Indian,
urs after aff, or its Examine	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces' 1 Yes 2 17 It Yes, Give Year or Datas:	No		it Yas, sp 1 ☐ Yes		Specify:	erto Hican, atc.)	Specify:	White, atc. White
72 ho	Completed	15. Decedent's E	ducetion		16a. De	ecedent's Us	ual Occup	ation		16b. Kind ot Bus	inass/Industry
Mad	ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	5+)	- (G	ave kind of wife. DO NOT	ork done use retired	ation during most of w d)	orkin g		
d with a series of the series	NO.	9	Conogo (1 40)	01,		Home	make	r		Ow	n home
ve at the se	Bec	17. Father's Nama (First, Middle, Last)					18. Mother's N	ame (First, Middle	, Maiden Sumama)
Aenta Aenta fic e	To	Andrew	Wilke	S				Ida	Mae	T e	homas
and 8		19a. intormant's Name/Relationship (Type, Print)		19b. N	failing Addres	ss (Street	and Number or	Rural Route Numb	er, City or Town, S	tate, Zip Code)
active ac		Bernice Vinch /	sister		11.	5 Chur	ch S	t., Bal	cimore, N	D 21225	
of He de		20a. Method of Disposition		20b. F	Place of Di	isposition (Na crematory or	ame of	ce)	Date	20c. Location - C	ity or Town, State
Page marit ry or		XX Burlai 2 Cremation 3 C 4 Donation 5 Other (Special	JRemoval from State v)					al Pk.	3/20/97	Glen Bu	rnie, MD
Appropriate (Section 1971)		21. Signature of Funeral Survice Lice)SA(e			22. Name a	nd Addre	ss of Facility			IIIC/ IID
Der Der Der Der Der Der Der Der Der Der		Jan State				CAFA	Stepl	hen D. I	Cohrmann	P.A.	
	-	23a. Part 1. Enter the disease or com	nlications that cause	d the deat	h Do not	8717	Gree	n Pastu	ces Dr.,	Baltimor	e, MD 21286
Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each I	ine.				9, 00011 00 00101	ar or raspiratory o		Approximata Interval Between Onsat and Death
/Medical		Immediate Cause (Final	050	100	1	1010	/	10	10.11	T	one
Examiner		disaasa or condition resulting in death)	a. CEY					77	7-cers	eur	Week
	9			Due to (d	or as a cor	nsequence ot):				100012
e ettending physician and od for use as the buriel-transit	Examiner		b	D /-		,					
physician and s the buriel-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events		Due to (c	ras a cor	nsequance of):				
sicia e bur	edicai	Cause (Disease or Injury that initiated events	C	Due to /o							
as th	8	resulting in death) Last		Dua to (o	rasa con	sequance ot)					
ettending for use	2		d								
d for	Cla	Part II Other eignificant conditions	natributing to death h		ulaine to ab			and a Daniel	ook Did	Anh	
een signed by the hould be detached	by Physician/M	Part II. Other significent conditions of						en in Part I.			ribute to the cause of death?
igned be det	V P	SUSPECTED	LUN	G	NE	OPLA	BM		- 10	Yes 2□No	3 Probably 4 Information
n sign										an autopsy	24b. Were autopsy findings
0 10	Completed								perfo	ormad?	available prior to completion of ceuse ot death?
C 0	E										
certificate rector, peg									10	Yes 2 PNo	1 ☐ Yes 2 ☐ No
ysician: is certific director,	Be	25. Was cese raferred to medicel examiner?	Hospital:				Oth	or:	eath (Check only		
this raidii	2	1 Yes 2 No 27. Manner of Death	1 LI Inpati			atient 3 D	OA	4L Nursing	7	dence 6 Other	11
Attending Physician: r death. ector: After this certific by the funeral director,	5	1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Tim Inju	ry	28c. Injur Wor	k?	28d. Describe	how injury occurre	d
death. ctor: Al	Certification:	2 Accident Investigation 3 Suicide 6 Could not b		Towns As he		M		Yes 2 □ No	Oth Leasting (Otenata and March	0
in Direct		4 ☐ Homicide determined	28e. Place ot in building, al	ic. (Specif	ome, tarm.	, street, tacto	ry, office		City or To	wn, State)	r or Rural Route Number,
within 24 hours efter death. To the Funeral Director: A completely filled in by the fi	2	200 Continu	1		V V						
Fun Fun	Jica	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	yaician: To the best niner: On the basis of	t examina	wledge, de tion and/o	eath occurred or investigation	at the tin	ne, date and pla pinion, death oc	ce, end due to the curred at the time,	cause(s) and men date and plece, er	ner as stated. Indicate to the cause(s)
thin	Medical	29b. Signature and Illin of certitier	and manner st	ated.		20	n Licens	e number		20d Data signed	(Month, Day, Year)
₹ \ 8	-	()	die A	10							
,		Amer					y 2	1776		MALCH	17 1997 MOCI 228
6		30. Name and address of person who				pe, Print)	0-	000-	^	14-1	M D 31.2
		Sury run	N ENG		203	E 1	4	arres	HUI	>ack lin	Jan Ses
Stat	te	31. Date tiled (Month, Day, Year)	32. Registi	rar's Signa	ture	· Mul	60				



BALTIMORE, MARYLAND

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TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed writin 24 hours after death. Page 5 may be retained by the holl	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detactive	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - STATE REGISTRAR		CERTIFI	CATE	F DEATH		REG. NO.		
1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH		3. TIME OF DEATH
	LEONARD B	OAK				MAPX	h 12	190	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (II	n yrs. last birthday)	IF UNDER 1 YE		68.40-06	OF BIRTH	8	BIRTHPLACE (State or Foreign Country)
	218-46-0997	1 M 2 □ F 5	O YRS.	MONTHS DA	YS HOURS MIN	Oct		146 1	MARYLAND
	9a. FACILITY NAME (If not institution, give str	reet end number)		9b. CITY, TO	WN DR LOCATION DE	DEATH	-	9c. COUNT	
DIRECTOR	Baltimore Vete	rons Hospita		BAH	Marc.				M/A
2	RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY	4	10c. CITY	, TOWN DR L	DCATION				10d. INSIDE CITY
E I	MARYLAND	%		BALTI	MORE				LIMITS?
	10s. STREET AND NUMBER				10f. ZIP CODE			10g. CITIZE	N DF WHAT COUNTRY?
FUNERAL	3812 HAMILTON	AVE			212	06		UNET	ED STATES
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN FORCES? 1 X YES	U.S. ARMED 2 ND		DECENDENT OF HIS			or No — 1	I. RACE — American Indian, Black, White, etc.
ВУ	1 Never Married 2 Married 3 Widowed 4 M Divorced	IF YES, GIVE WAR DR DA	TES			ecify:			Specify: WHITE
		VIETNAM	ERA 16a, DECEDENT'S	100000	2470041	T 401	, KIND OF BU	DIVIDO (IND.)	
E	15. DECEDENT'S EDUC (Specify only highest grade	completed)	(Give kind of w	vork done durin	g most of working	100			
PE	Elementary/Secondary (0-12)	College (1-4 or 5+)	CONDU				RAIL	ROAD	•
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		1		16. MOTHER'S		Middle, Melden	Surname)	
BEC	CORTLAND		BOAK		Here				WITZ
2	ANDREA SERENE	50			eet end Number or Ru	-			MB 21206
	ANDREA SERVICE 200. METHOD OF DISPOSITION	_	PLACEANDDATED			2/ DA/	1111		ty or Town, State
	1 Burial 2 Cremation 3 Ramo				REMATTERY	1/18/9	7 B		HES MD
	21. BIGHATURE OF FUNERIAL SERVICE LIC		10 11 17 17	22. NAN	A STEPHE	FACILITY	HRM	ANN E	4.
	* Story A X	Was - Class	_		7 GREEN F				TIMBRE MB
	23. PART I. Enter the diseases, or o	complications that caused	the death. Do n					iratory arres	st, Approximate
	shock, or heart fallure.	List only one cause on e							Interval Between Onset and Death
	IMMEDIATE CAUSE (Final disease or condition	Snootane	b	4	cocitan	120			70046
-	reaulting in death)	DUE TO FOR AS A	CONSEQUENCE OF	F):	Pernon	1115			Tauys
_		ascites							14days
9	Sequentially list conditions, If any, leading to immediate	DUE TO (DR AS A	CONSEQUENCE OF	F);					2
B	cause, Enter UNDERLYING CAUSE (Disease or Injury	. Liver C	ALCINO	MA					& Months
L.	that initiated events		CONSEQUENCE OF						
CERTIFICATION	reaulting in death) LAST	d							
	PART II. Other aignificant condition	a contributing to death b	ut not resulting	in the unde	iving cause giver	ı In Part I.	24a. WAS AR	AUTOPSY	24b. WERE AUTOPSY FINDINGS
S					, -		PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE
ED							1 TYES	2XNO	OF DEATH?
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTI	PIRLITE TO CALISE C	E DEATH YE	S I NO	UNCERT	AIN X			1 TYES 2 ND
AN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT			All I EX			
SICI	EXAMINER?	HOSPITAL:	atlent 3 DOA	OTHER:	Home 5 - Resider	nce 6 Oth	es (Snecify)		
H H	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIM	E OF 28	c. INJURY AT	- 1	SCRIBE HOW	INJURY OCCU	JRED
	1 X Natural 5 Pending Investigation	(Month, Day, Year)	IN.	M 1	WORK?				
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	- At home, farm,	street, factory,	office	261, LO	CATION (Street	end Number o	r Rural Route Number,
COMPLETED	4 Homicide determined	building, atc. (Spec	агуу			Unj	or Town, State	,	
PLE	29e. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of my know	ledge, death occurr	ed at the time	date end place, and	due to the co	ruse(e) end ma	inner se state	d.
OM	4-41	R: On the basic of examination	n end/or investigation	on, in my opin	ion, death occured at	t the time, dat	e and place, a	nd due to the	cause(e) and manner ee stated,
	296. SIGNATURE AND TITLE OF CERTIFIE	R			29c. LICENSE	NUMBER	-	29d. DATE	SIGNED (Month, Day, Year)
TO BE	Hillorah So	m M	, D.		P097	58		► ma	vch 14, 1997
-	Debotah Som	10. 10.0	Steene	di	Bayto.	hud.	21	201	
	31. DATE FILED (Month, Day, Year) MAR 1 8 199	7 Gulia Jan	ATURE Rand	4000					
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth JAMES 1100 BENNETT 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Baltmore If Under 24 Hrs. 8. Date of Birth Min. Month, Day, Year) 7. Age (In yrs. lest birthday) Jurch Home 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) Days 1 M 2□ F 17-38-5784 2 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No e 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 508 Drad 21205 12. Was Decadent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No 3 Widowed 4 □ Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) long Shore man Elementery/Secondary (0-12) College (1-4or 5+) abover unknown 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) SoloMon Kennick 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Da Himore 20b. Placa of Disposition (Neme of cometery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1. Burlal 2 □ Cremetion 3 □ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansee 22. Name and Address of Fecility H.Wesi ans 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fellure. List only one ceuse on each line. 40 Md 21213 Levenue Approximete Interval Between Onset end Death with Inclastages Immediate Cause (Final quais disease or condition resulting in death) Due to (or as e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or as a consequence of):

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

Md

Funeral

Director

28a-f show

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traumetic event,

the Medical Examiner must be notified at

Funeral Director

Completed by

Be

death with the Maryland

Pages 1 end 2 should be filed within 72 hours after

21215-0020

Baltimore, Maryland

ires that the death certificate be executed

P.O. Box 68760,

Vital Records,

Division of

igned by the attending physician be deteched for use as the burie igned by After this Certification:

Physician/Medical þ Be Completed 2

or Attending Physic deeth. within 24 hours after deetl To the Funeral Director: filled in by e S

> State Registrar

Medical

(Check only

29b. Signature and title of certifier

Examiner

25. Wes case referred to medical examiner?

1 ☐ Yes 2 No 27. Manner of Deeth 1 Naturel 5 Pending investigation 2 Accident 3 Suicide

4 Homicide

6 Could not be determined

ialutes

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Tellitus

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Due to (or es e consequenca of):

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 1 Yes 2 No

29c. License number

40356

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

26. Plece of Death (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated.

20 No

Dellerance me perialist

100 A- Browlets

29d. Date signed (Month, Day, Year)

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No

24e. Was en autopsy performed?

1 🗆 Yes

28d. Describe how injury occurred

3 Probably 4 Unknown

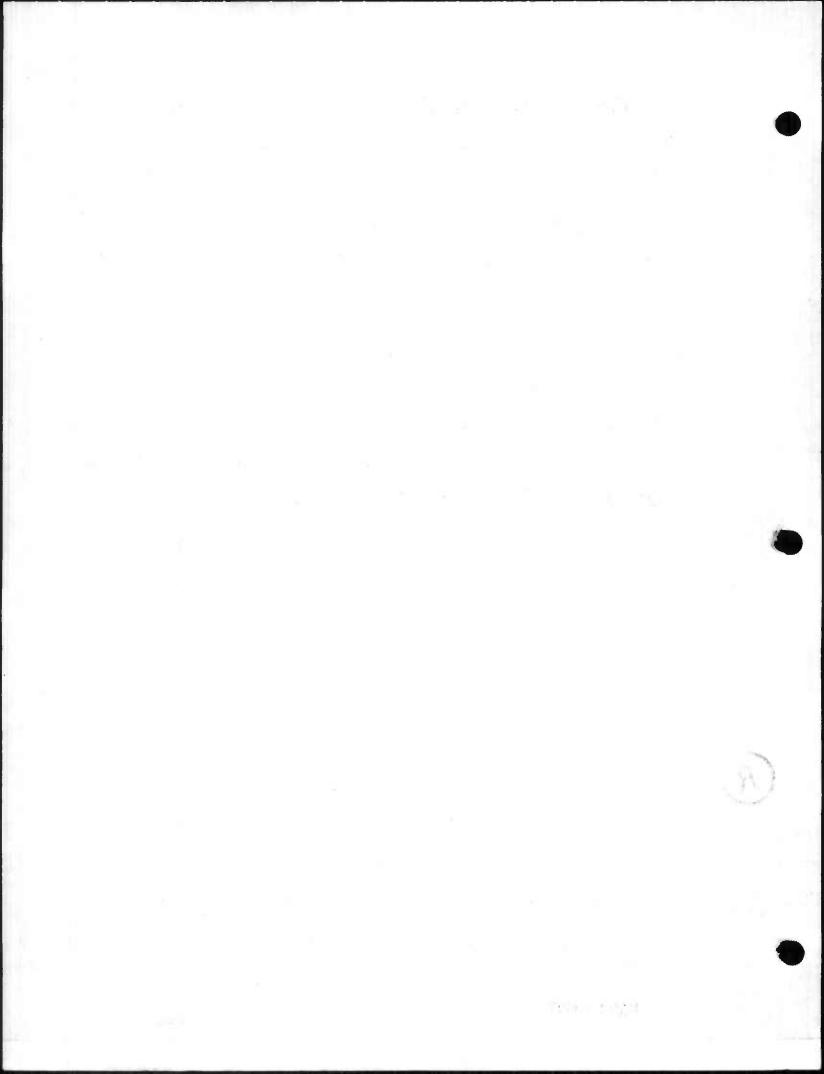
24b. Were autopsy findings eveileble prior to completion of cause of deeth?

1 ☐ Yes 2 ☐ No

30. Nama and eddress of person who completed cause of deeth (Item 23e) (Type, Print) WENEUSAT. NAVARTLO

31. Dete filed (Month, Dey, Year) MAR 18 1997

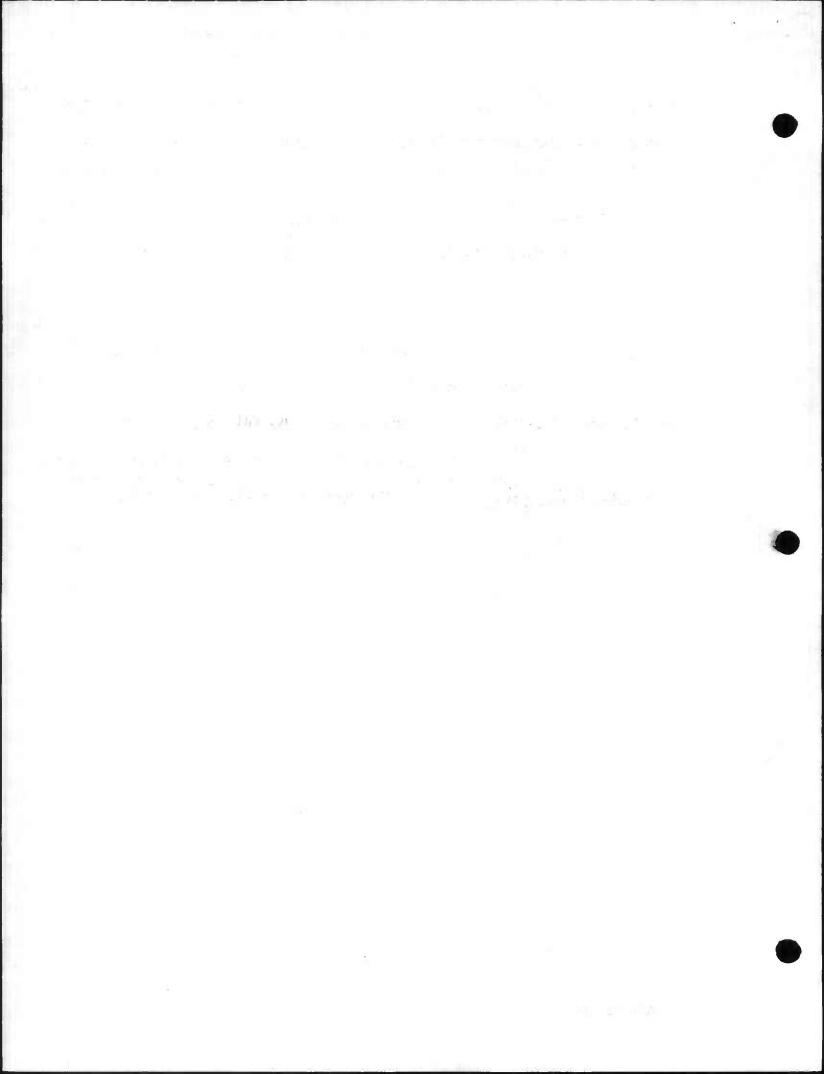
32 Aegistrate Signature Randall



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	yland		10a. Stata 10b. County		10c. City, Town or	Location		.=			10d. In	side City Limits			
	Ba-f st	ctor	Md. Baltimo	re			Par	rkville			1	☐ Yes 2 No			
	or 20	Dire	10e. Street end Number			10f. Zlp	Code	01006		10g. Citizen of Whet Country?					
	a 23e	erai		Walther Bl		2 Was David	21236				States				
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Maryland		To B		Henry J.	Bauer Sr	•			Mary Nut	h					
Jan	and and is m		19e. Informant's Name/Reletionship		19b. Me	iling Address	(Street	end Number or Ru	rai Route Number	r, City or Town	, Stete, Zip Code)			
	Haaii Haaii Haaii Haaii		Mary E. Bauer (Sister)	20b. Plece of Dis			r Blvd. B			21236	tata			
TOL	as of the		100. Method of Disposition 1												
Baltimore,	그는무를		21. Signature of Funeral Service Lice		night Jr	22. Name en									
m	Depariment of the population o		5305 Harford Road Baltimore, Maryland 21214 23a. Penti. Enter the disease, or compliant that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate												
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N N	F 2 - C	Certification:	3 Sulcide 6 Could not be determined		y - At home, farm, (Specify)	street, factory	, office		28f. Location (Si City or Town	reet and Numi n, State)	ber or Rural Rou	te Number,			
	To the Hospital c within 24 hours al To the Funeral D complataly filled i	edical	29a. Certifier (Check only one) Certifying Pi	nysictan: To the best of ninar: On the besis of e and menner stete	xaminetion end/or	ath occurred a Investigation,	at the tin	ne, date end place pinion, death occur	, end due to the carred et the time, d	ause(s) and mate and place,	anner as steted. end due to tha d	ause(s)			
	To 1 To 1	M	29b. Signetura and title of certifiar	00:				a number			d (Month, Day,	(ear)			
	\sim			mark		-	BY	0480		Man	6 17,1	777			
	10		30. Name and eddress of person who	completed ceuse of dea	ath (Item 23a) (Typ	e, Print)	55	0480 10 Bell 140, MI	812 184	6					
1	Sta	te	31. Dete filed (Month, Day, Year)	32. Registrar	's Sign Handal			1							

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Month WILLIAM BLACK 0546 AM MAR 1997 /Medicai 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** ST. AGNES HOSPITAL BALTIMORE NONE 5. Sociel Security Number 6. Sex 1#☐ M 2□ F If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 73 Yrs Director N.C. 242 26 1557 the Maryland 10a State 10b County 10c. City, Town or Location worle 10d. Inside City Limits ral', or items 23s or 28s-f sh Examiner must be notified Director 1 WYes 2 □ No MD. NONE BALTIMORE 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 808 LYNDHURST STREET 21229 USA Pages 1 and 2 should be filed within 72 hours after death valuet of Heelth end Mantal Hygiane.
Ant If Hem 271s merked other than "natural", or Hems 23sury or other traumatic event, tra Medical Examinat must by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1#1Yes 2 □ No If Yes, Give Year or Detes; 1 ☐ Never Married #☐ Married **AFRO** 1/46 21215-0020 1 ☐ Yes 2# No Specify: AMERICAN 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade Elementary/Secondary (0-12) College (1-4or 5+) S.S.A. 12 CLAIM OFFICER Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be BLACK KATIE HART 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LILLIAN BLACK 808 LYNDHURST ST. BALTO. MD. 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State #☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) GARRISON FORESR 1/18/97 OWINGS MILLS, MD. 21. Signature of Fungral Service Licenses 22. Name and Address of Facility ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or hear failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final ACUTE MYOCARDIAL INFARCT min disease or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner CARDIAC ARRHYTMIA mm The law requires that the death certificate be executed Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Lest attending physician end for use as the bunel-trar P.O. Box 68760. Physician/Medicai Due to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 JUnknown RENAL FAILURE Division of Vital Records, Completed by 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Was an autopsy performed? HYPERKALEMIA peed 1 Yes 2 No 1 Tyes 2 No 25. Wes case referred to medical examiner? 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Netural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or Within 24 hours at To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and piece, and due to the cause(s) and manner es stated. Medical 29a. Certifier Territying Physician: 10 the best of my knowledge, death occurred at the time, date and piece, and doe to the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner steted. 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 29c. License number lomsay 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) KONGSAK CHANTORNSAENG ST. AGNES HOSPITAL 900 CATON AVE. BALTIMORE, MD. 21229 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 18 1997 Registrar

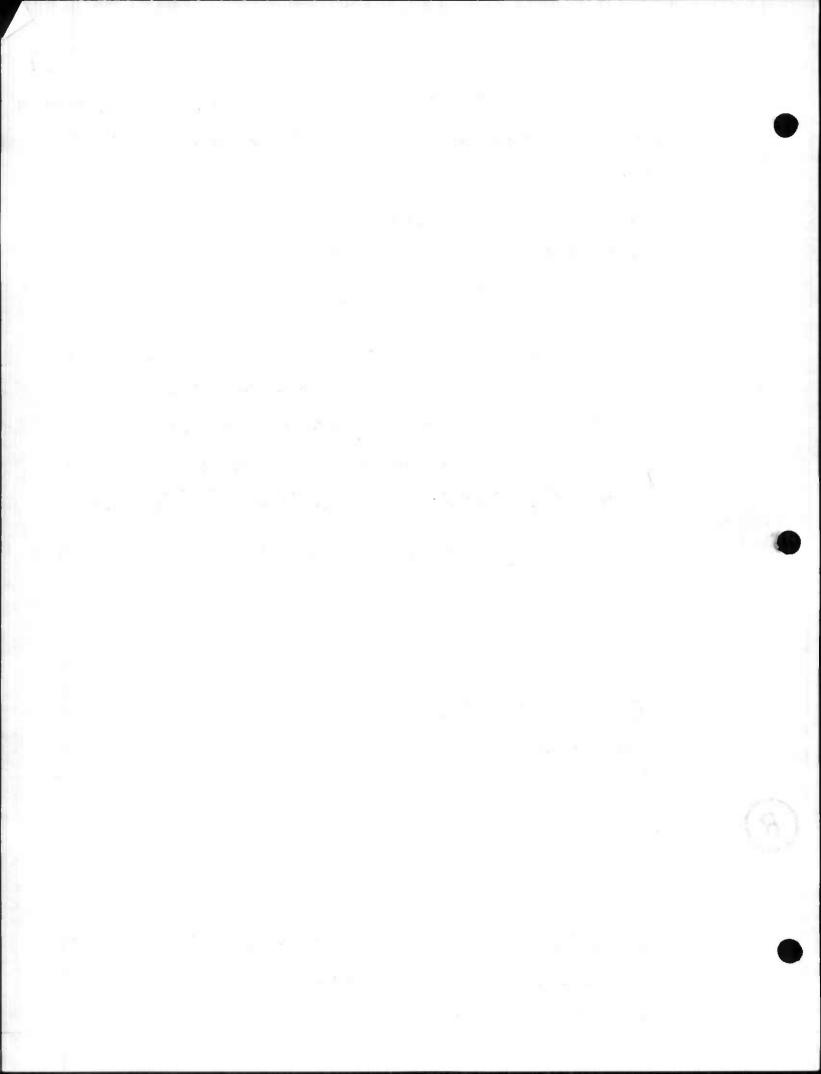
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State of Maryland / Department of Health and Mental Hygiene 97 08077

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			THE JOHNS HO								,MARYL		C	ITY	
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	yland		10a. State 10b. County		10c. City,	Town or Lo	ocation							100	d. inside City Limits
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	or 28	Director	10e. Street end Number				10f. Zip					10g. Citize	n of Wh	net Countr	y?
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	ems ems	Funeral	11. Maritel Status	12. Was Decedent Armed Forces?	Ever in U,S.	13.	Was Deced	dent of H	lispanic Orl	lgin? (Spe	ecify Yes or No	- 14		- Americar White, et	
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_			Ross Sum	ner 6		root	h v	Vol	te s	tree	t Bo	Itima	re	Man	land
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Item8 3-18-97 FilmG745 W.H. Per F/H

State of Maryland / Department of Health and Mental Hygiene

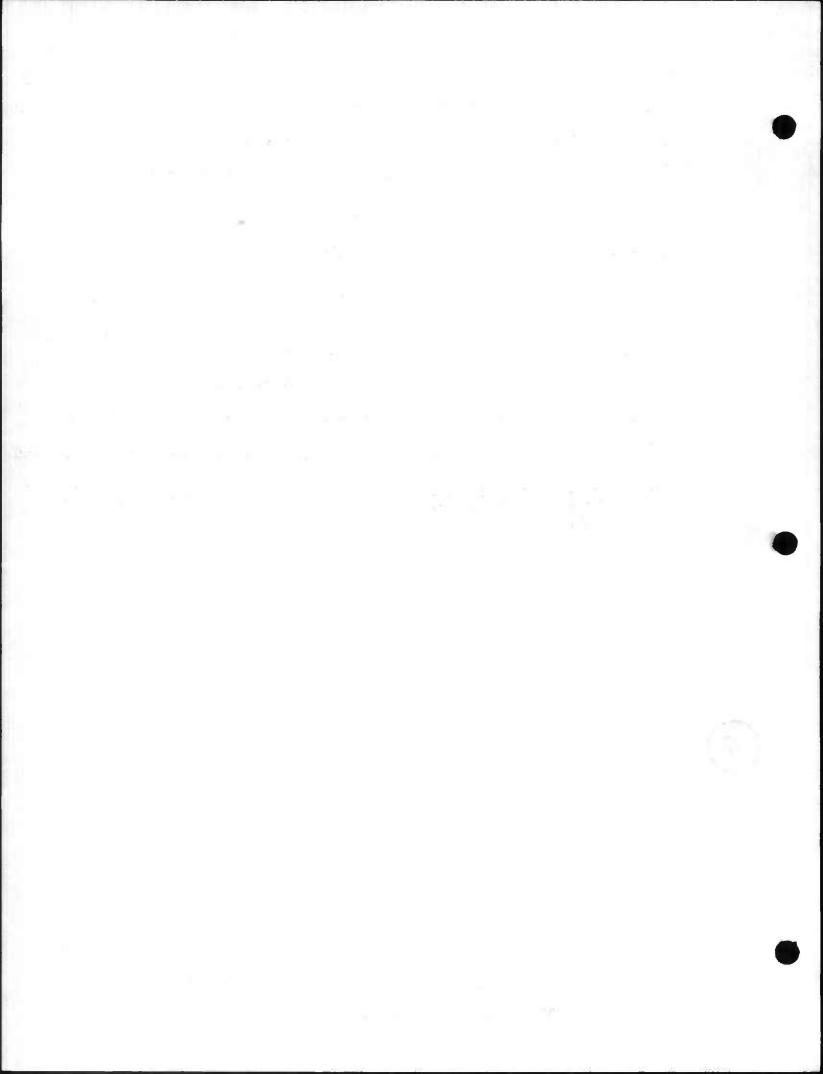
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/Medi		Brenda Bell			1997 17:06
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·	ш,	Union Memorial Hospital	BALTIM		ne
Funeral Director		5. Social Sacurity Number 3 6. Sex 1 M 2 F 7. Age (In yrs. 55)	Months Days Hours Min.	8. Data of Birth 1942 (Month, Day, Year) (Corvey 10, 1997	9. Birthplaca (State or Foreign Country) HARY AND
and *		Usual Residence of Decedent 1Qa. State 10b. County 10c. Cit	ty, Town or Location		10d. Inside City Limits
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the Mar 28a-f sl	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of V	
th with 23a or	erai Dir	4435 Eldone Rd.	21229	USA	7
- je 2 2	/ Funeral	11. Marital Status 12. Was Decedant Ever in U Armed Forces? 1 \[\Delta \text{Never Married} \] 11. Was Decedant Ever in U Armed Forces? 1 \[\Delta \text{Never Married} \] 12. Was Decedant Ever in U Armed Forces?	,S. 13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexicen, Puerto Ri 1 ☐ Yes 2 ☑ No Specify:	ify Yas or No- ican, etc.)	e - American Indian, ck, White, etc.
5-0020 72 hours of natural', or dical Express	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	12 165 Zyayto Specify.	ATTE	AMERICAN
5 2 Ta	ete	15. Decedent's Education (Specify only highest grada completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Bu	usiness/Industry
ore, Maryland 2121. s 1 end 2 should be filed within if Health and Mental Hygiene. item 27 Is marked other than rights traumatic event, its West	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life, DO NOT use retired)	serf	
ind 2 be filed tal Hygid d other	Be	17. Eather's Neme (First, Middle, Last)		First, Middla, Maiden Surnam	a)
arylar should be nd Menta marked matic ev	10	CARL HENDERSON	Reith B	works, Hend	liste
Maryland d 2 should be flight and Mental Hy 7 Is marked oth traumatic event	Γ.	19a. Aformant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Numbar or Rural	Route Number, City or Town,	State, Zip Code)
e, M		Darry M. Bell	4435 Eldore Rd	BALLO, M	L 21229
		1 2 Cremation 3 Ramoval from Stata	Place of Disposition (Name of emptery, crematory or other place)	Date 20c. Location - OWIND.	City or Town, Stata
Baltimo		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Sarvice Licenses	22 Name and Address of Facility C		
Balti permit. Departm Importar any Inju		Mules mi Luclice	22. Name and Address of Facility 3.46 Wallace Funesci Service BA	Londa Ma	
		23a. Part Enter the disease, or complications that caused the death shock, or hear of ilure. List only one ceuse on each line.	h. Do not entar tha mode of dying, such as cerdiac or	raspiratory arrast,	Approximate Interval Between
Physician					Onset and Deeth
/Medicai Examiner		Immediate Cause (Final disaase or condition	HEART FAILURE		6 DAYS
Examiner		103 diting in doubt	or as a consequence of):		60,775
D 45	ine	- RIGHT V	ENTRICULAR ENFAI	RCT	8 DAYS
8760, sete be executed hysician and the buriel-transit	Examiner		or as a consequence of):		
Se ex se ex cian c		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	AORTIC DISSEC	TION	11 DAYS
68760, ificete be exe g physician e as the buriel.	edicai	thet initiated events rasulting in death) Last Dua to (or	r as a consequance of):		
death certificate be executed that the season and the for use as the buriel-transition of the season and the season are the season and the season are the season and the season are the season are season as the season are s	2	d. HYPER.	TENSION		loyerrs
O. E. the deat the dath	Physician/	Part II. Other eignificant conditions contributing to death but not resu	ulting in the underlying cause given in Part I.	23b. Did tobacco uee cor	ntributa to the cause of death?
P.O.	h.				3 Probably 44 Unknown
100	by	MULTISYSTEM FAIL			
Division of Vital Record or Attending Physician: The several plate death. Director: After this certificate mas earlin by the funeral director, page 2 county	Completed	LEFT PLEURAL	E FF USION	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
The la	E			1 □ Yas 202 No	
f Vital Rysician: Tressis certificate to		25. Wes case referred to medical	OC Pleas of Parth /		1 ☐ Yes 2 ☐ No
Sicie s cent	To Be	axaminer? 1 ☐ Yes 25 No Hospitai: ☐ Inpatiant 2 ☐	26. Place of Deeth (
Of Phy Phy rrthis			Envoulpatient 3L DOA 4L Nursing Home	a 5 Rasidence 6 Other	
On ding th. Afte	tior	27. Menner of Death Dianaturai 5 □ Pending 2 □ Accident invastigation 28a. Date of Injury (Month, Day Year)	Injury Work? M 1 Yes 2 No		
Viten dea ctor.	Certification:	3 Cuicide 6 Could not be		f. Location (Street and Number	er or Rural Routa Number
Div June	ert	4 Homicide building, etc. (Specify	ome, farm, street, factory, office	City or Town, State)	or or rioda rioda rioda,
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,		29e. Certifier Certifying Physicien: To the best of my know	wledge, death occurred at the time, date end place, and	d due to the cause(s) and	nner as stated
24 h Eur etely	edical	(Check only one) 2 Medical Examinar: On the besis of examinat and manner stated.	tion and/or Investigation, in my opinion, death occurred	at the time, dete and place, a	and due to the ceuse(s)
omp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed	(Month, Day, Year)
- > - 0		MA	7 41637		
, N	+	30. Name and address of person who completed cause of deeth (item	23a) (Type Print) (1 h 1 1 0 N	MARCH	NO (PT DA)
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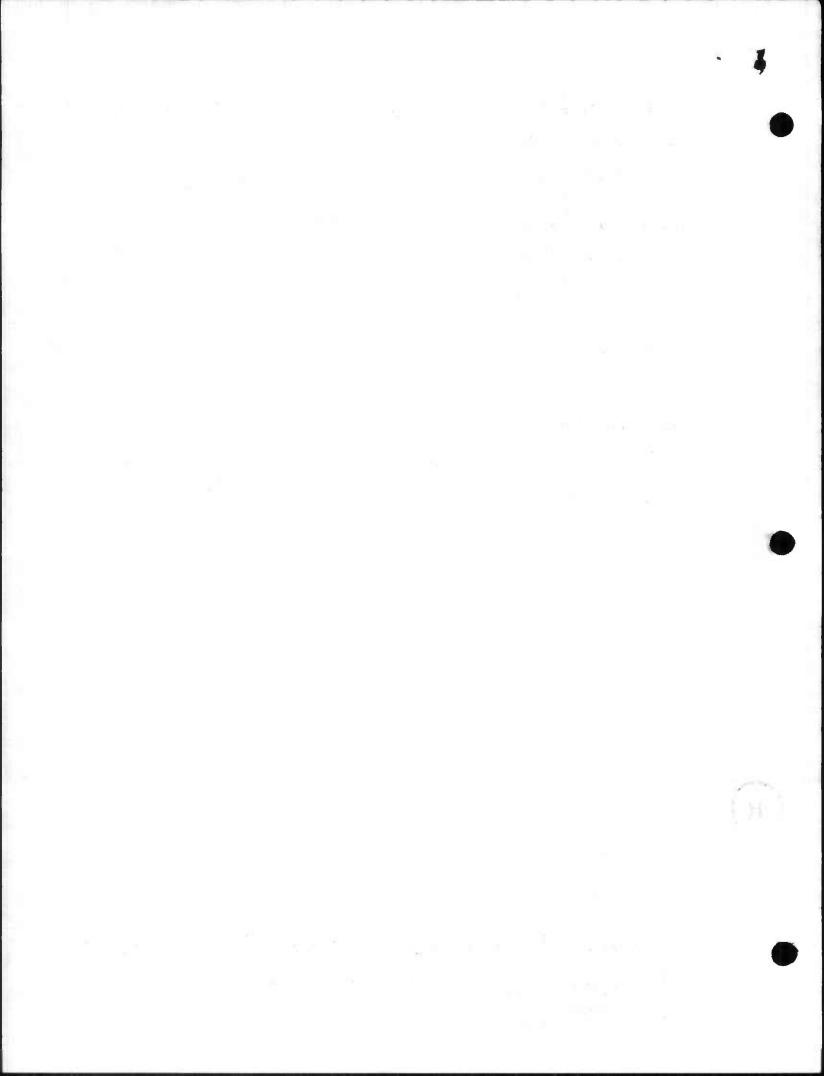
State of Maryland / Department of Health and Mental Hygiene

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	r 28a-f ehow	tor	Usual Rasidance of Decedent 10a. Stata 10b. County MD N	/A		own or Location	re				10	0d. Insida City Limits 1 ☑ Yas 2 ☐ No	
	th with the 23e or 28e	Funeral Director	10e. Street and Number 2716 Woodlan	d Avenue		10f. 2	ip Coda 21	215		10g. Citizen of What Country? U . S . A .			
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	f Health end I them 27 is me other traums		19a. Informant's Name/Ratationship Joyce Coates/			2716 W	ood1	and Number or Ru and Ave	nue, B	alto.,	MD	21215	
Baltimore,	8 = 5		20a. Method of Disposition 1	oify)	20b. Place cema Mt.	of Disposition (A tary, cramatory o Zion C	othar place emet				ore,	Marylan	
Ba	permit. Pa Departmen Important any injury and injury		21. Signature of Funaral Sarvice Lic	0 14	ell	4600	LIB	ERTY HE	IGHTS .	AVE.,B	L HO	ME, P.A. 21207	
1	Physician /Medical Examiner		23a Can Extens the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Immediate Cause (Final disease or condition resulting in death) NARCOTIC AND COCAINE INTOXICATION Due to (or as a consequence of):										
0X 68/6U,	hat the death certificate be executed by the attending physician end attended for use as the bunlet-transit	Physician/Medical Examiner	Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated avants rasulting in death) Last	c		a consequance o	,						
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VII	Physician: The rthis certificate are director, par	Be	25. Was cese referred to medicel examinar?	Hospitali	-		Oth		1,20°	Yas 2 No	UP.	JYas 2□No AT	
	ng Phys fter this meral di	Certification: To								dance 8 🛚 Otto how Injury occu ngested (rred	SCENE	
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	the Ho hin 24 t the Fur npletely	Medicai	(Check only one) 2X Medicai Exp	minar: On the basis of and manner sta	axamination a	and/or investigation	n, in my o	pinion, daath occu	rrad at the tima,	date and place,	end due to	the ceusa(s)	
	will To Con	~	29b. Signatura and titla of certifiar	h Nac	els	MP	9c. Licans	. C.M.E.		29d. Data signo		1997	
	Sta	ite	30. Name and eddrass of person who Strphro S, Pa a 31. Dete filed (Month, Day, Year)	d x n 1 Z, N) 32. Registra	ρ 11 ar's Signatura			eet, Ba	ltimor	e, Mar	yland	d 21201	



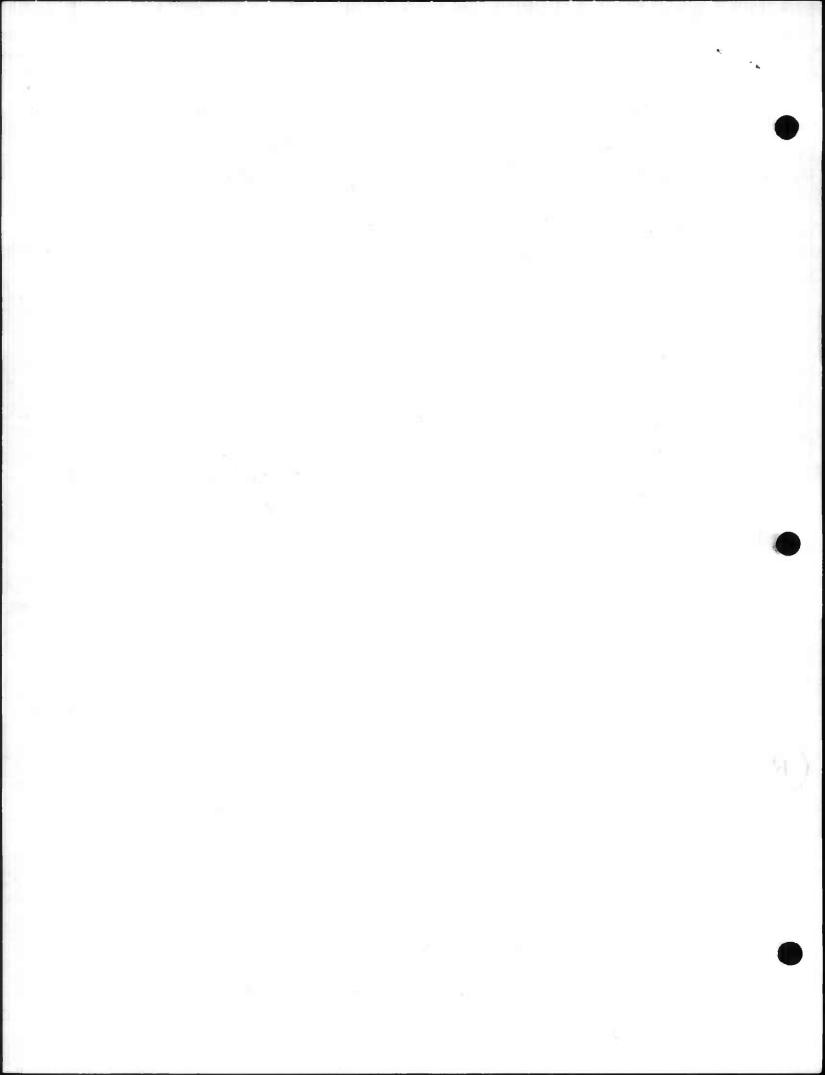
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** FONAR RDSC 7.53A /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** ABUNDANT LIFE Home No BALTIMORG If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 5ex 1☐M 2☐F Months Deys Yrs. 217-34-4750 Director 9.1911 Maryens 86 JAN. Usuet Residence of Decedent with the Maryland 10e Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f ahow traumatic event, the Medical Examines must be notified at 1 Tes 2 No PHINCE MITCHELLVILLE Harylow Direct 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 20720 2105 USB permit. Peges 1 and 2 should be filed within 72 hours after death a Department of Heelth and Mental Hyglene. Important: If item 27 is marked orther than "natural; or freme 23s any injury or other tranmatic event, the Modific Example man Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritet Stetus 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 10 Specify: Specify by 3 ☐ Widowed 4 ☐ Divorced Black Completed 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) BLITZES LOUNGE College (1-4or 5+) BARTOLDER 8th grade 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Margaret BESSES CALVIN J. Cross 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MitcHelluille, Mary Love 1 2105 CIEPE Court PAUL COBY Granoson 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 Duriel 2 Cremetion 3 Removel from State WOUD CAUN, Haryland 4 □ Donetion 5 □ Other (Specify) DODESUN Comekry 22. Name end Address of Fecility CHA TAIRS - HARRIS FUNERAL HOME 5346 REISTERSHOWN ROOD 21. Sloneture of Funeral Service Licensee any in 23e. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or hearly fellure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical tmmediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examine that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last attending physiclen and for use as the burtal-tran Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): ed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 Yes 2 No 3 Probably 4 Unknown Records. Š law requires 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy performed? has 10 2 1 ☐ Yes 1 Yes 2€No Be 25. Wes case referred to medical examiner? 26. Placa of Deeth (Check only one) 4ROUP Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner_of Deeth HOME 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending Investigation 1 DNaturel Hospital or Attendir deeth. 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of injury - At home, ferm, street, fectory, offica building, etc. (Specify) 3 4 Homicide ă To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and piace, and due to the cause(s) end menner stated. 29e. Certifier Medical 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) N. EUTAW ST # 305 BACTIMOR REKRISHIVAN, 821 2/20 31. Dete filed (Month, Dey, Year) 32 Registrer's Signeture 9 1. State MAR 18 1997 Registrar

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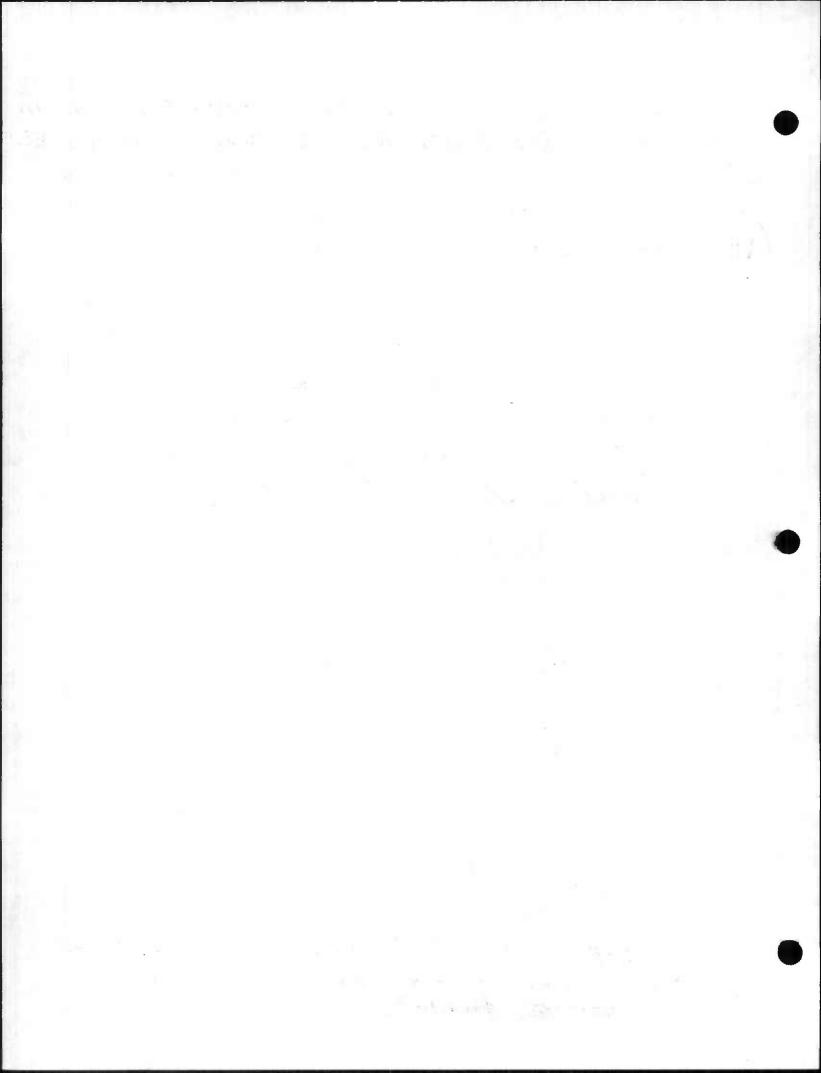
State of Maryland / Department of Health and Mental Hygiene

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	/Medi		LILLIAN	L				HESTER	MARCH	1 16, 1		128AM		
	Exami	ner	4a. Fecility Neme (If not institution, gi		per)			4b. City, Town, or L	ocation of Deat	h 4c. County	of Deeth			
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	Funeral Director			Sex 7	SS	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Dete of Bir (Month, De	th ly, Year) 1,19 th	9. Birthplace (Country) Maryl &	Stete or Foreign		
	land wo		10e. Stete 10b. County		10c. Cit	y, Town or Lo	cation				10d. In	side City Limits		
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	r 288	irec	10e. Street end Number	/ 10		1013//	10f. Zip Code			10g. Citizen of N	Whet Country?			
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Maryland	d 2 should th and Mer 7 is marke traumatic	To	19e. Informent's Neme/Reletionship Sterling Couso	(Type, Print)		19b. Mailin	g Address (Street	end Number or Ru	Tal Route Numb	er, City or Town, SIEVE	State, Zip Code	AMZERA		
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	V vit	2	29b. Signeture and title of certifier Onald	& Wru	ght N	10	29c. Licens	C.M.E.		29d. Dete signe	16, 1			
	Uj		30. Name and address of person who DONALD G. WR	completed cause			Print)	reet, B	altima					
	Sta	te	31. Dete filed (Month, Dey, Year)	32. Reg	istrer's Signe	ture				_ 0 , 110	- y runu	LIZUL		



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Physic		1. Decedent's Nama (First, Middle, La:	st)	0	cate of Death	2. Data of Month	Reg. No.	1007 012
/Medi- Examin Funeral Director		4a. Facility Nama (If not institution, giv. North ARU) 5. Social Sacurity Number 6. S 107 05 6011	DEL HOSPI	TAL A	55N G/e/		4	y of Death Ne ARUNI 9. Birthpiaca (State or a Country) New York
1	tor	Usual Rasidanca of Dacadant 10a. Stata 10b. County Maryland Anne Ar		y, Town or Location	Glen Burn	ie		10d. Insida City
WH	arthrec	10e. Street and Number 6656 Shelly Rd.	Apt 191	11	Of. Zip Coda 2106	1	10g. Citizen of United	
at. or hams	by Funer	11. Marital Status 1 ☐ Naver Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedant Evar in U Armed Forcas? 1 ☐ Yas 2 X No If Yas, Giva Yaar or Datas:	If Yes	Decedent of Hispanic O , specify Cuban, Maxica as 2 X No Specify		No- 14. Rad Bla Specif	ce - Amarican Indian, ck, Whita, atc.
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alth and M 27 is man r traumat	1	19a. informant's Name/Raiationship (7 Marilyn Doyle / n			drass (Street and Number and Numb		nber, City or Town	, State, Zip Code) 21146
nent of Her ant: If Nem ary or othe		20a. Mathod of Disposition 1 Burlal 2 Cramation 3 4 Donation 5 Other (Specify	Removal from State	lace of Disposition emetery, cramator	(Name of	Date 3/17/97	20c. Location	- City or Town, Stata
Departr Importa any Inje odce.		21. Signature of Funeral Sproige Licep		22. Nar CAF	na and Addrass of Faci A Stephen I 7 Green Pas	D. Lohrmann	P.A.	ore, MD 212
ng physician and as the bunal-transit	Pa	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents rasulting in death) Last	b. DIFFUSE Due to (o Due to (or	as a consequance	117AL L 0 of): ENSE 0 of):	emplitysi	SOURCE	10 ym
igned by the attendin be datached for use	Physician/N	Part II. Other significant conditions co	d. KEU NOCYTO				d tobacco use co	ntributa to the cause of
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certificata l rector, pag	Be	25. Was casa rafarred to medical axaminer?	Hospital;		26. Plac	1 E a of Death (Check only	Yas 2 No	1 □ Yas 2 Ø N
After this funeral di	Certification: To	1 Yas 2 No 27. Manne of Death 1 Haturai 5 Panding invastigation 3 Suicida 6 Could not be		ma 5 Rasidance 8 Othar (Specify) 28d. Dascribe how injury occurred				
within 24 hours eftar deeth. To the Funeral Director: A completely filled in by the funeral Director.		4 Homicida datarmined 29a. Cartifier V Certifying Phy	building, atc. (Specify	vledga death occu	rred at the time, date as	City or T	own, State)	per or Rural Route Numbe
thin 24 or the Fu	Medical	(Check only 2 Medicat Examilation) 2 Medicat Examilation Medicat Examilation (Check only one) 29b. Signatura and title of certifier	ner: On the basis of axaminat and mannar stated.	ion and/or Invastig	ation, in my opinion, dea	ath occurred at tha time	a, date and place,	and due to tha cause(s)
₹ E 8		30. Nama and addrass of person who co	mo		D43977		March	d (Month, Day, Year)
5		I Nama and address W seems ut	maniple occupa of death //	220) /Time Down				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death CARTER MAR MILTON LYAL 08-30 AA 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Agnes Hospital Baltimore 7. Aga (In yrs. last birthday) | If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foraign Country) 1 1 M 2 □ F Days 220-14-4041 Yrs. 93 Virginia April 8, 1903 Usuai Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Maryland Baltimore County Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2203 Alvin Avenue 21228 USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ Yas 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 200 Married 1 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedant's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work dona during most of working lifa, DO NOT use retired) Eiementary/Secondary (0-12) College (1-4or 5+) 6th maintenance Baltimore Transit Co. 17. Fsther's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Howard Carter Annie (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Ms. Gladys Carter/spouse 2203 Alvin Avenue, Catonsville, Maryland 21228 20b. Pisce of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 15 Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. John's Cemetery 3 - 18 - 97Ellicott City, MD 21. Signature of Funeral Sarvice Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. MO0535 Ellicott City, Maryland 21043 Fig. 2.1043 Ellicott City are accomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate interval Between Onsat and Death immediete Cause (Finai BLEEDING disease or condition resulting in death)

Physician /Medical Examiner

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physician (s the buriel

Records, P.O. Box 68760.

Division of Vital

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Physician

/Medical

Examiner

Director

Funeral

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Examiner

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Director

ò must be

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altimore, Maryland 21215-0020

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initisted events resulting in death) Last

PNEUMONIA Due to (or as a consequence of) Due to (or as a consequence of):

Physician/Medical Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was en sutopsy performed? Completed perto 1 Yes 25 No 1 Yes 2 TNo 25. Was case referred to medical examiner? 26. Piace of Death (Check only one) Hospital: 1 Hipatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 PNeturai 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piace of injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and piece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and little of certifier 29d. Data signed (Month, Day, Year) 021649 askerran

30. Name and address of person who completed cause of deeth (item 23a) (Type, Print) S. BAS KARW 3455 W. KRW

M. Baltimor MD 2122

Registrar

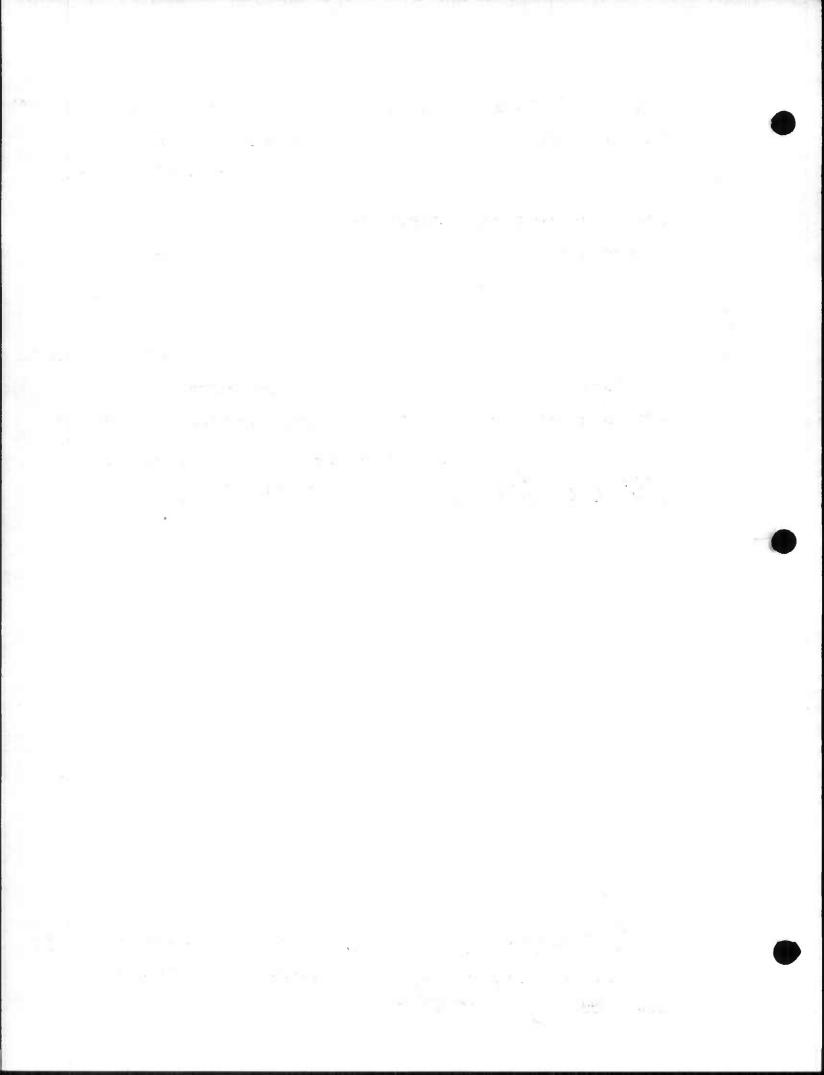
Medical pletely

funeral

I or Attending F after death. | Director: After

24 hours a

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month Albert Francis Connolly March 1997 5:45 pm 16 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Queen Anne Drive Parkville Baltimore Co. Months Days Hours Min. January 22, 1909 5. Social Security Number Birthpiaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) Months 100 M 2□ F 216-10-6333 88 Yrs Maryland Usual Rasidance of Decedant 10a State 10h County 10c. City. Town or Location 10d. Insida City Limits Maryland Baltimore 1 TYAS 2 NO NO Parkville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 7710 Queen Anne Drive 21234 United States 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-it Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2 🕱 No If Yas, Giva Yaar or Datas: 1 ☐ Yas 2 X No Specify: 3 ☐ Widowad 4 ☐ Divorced Specify: White 15. Decedant's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 18b. Kind of Business/Industry Eiamantary/Secondary (0-12) Collaga (1-4or 5+) Photographer Aluminum Company 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) James Connolly Katherine Rittershofer 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Mrs. Minnie V. Connolly / Wife 7710 Queen Anne Drive Parkville, Md. 20a. Mathod of Disposition 20b. Piaca of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cramation 3 Ramovai from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Parkwood Cemetery 3/19/97 Baltimore, Maryland 21. Signatura of Funaral Sarvica Licansee Mark T. Zavoyna 22. Nama and Addrass of Facility Leonard J. Ruck Funeral Home, Inc. marke Tis 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Entar tha disaasa or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina. Approximata Intarvai Batwaan Onsat and Death ACUTE MYOCARDIAL INFARCE immadiata Causa (Final disaasa or condition rasulting in daath) Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last Dua to (or as a consaguanca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 BNo 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 PNo 1 ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical axaminar? 1 ☐ Yas 2 ☑ No 26. Placa of Daath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Assidanca 6 Othar (Specify) 27. Manney of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of

Physician /Medical Examiner ician end burial-transit

Physician

/Medical

Examiner

Director

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7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at

nit. Pagas 1 and 2 should be filed within 72 hours after armen of Health and Mentel hygiene. ortant: If item 27 is marked other than "naturel", or ite inlury or other traumatic event, the Medical Experies

permit. Page Department Important: If any Injury or

Baltimore, Maryland 21215-0020

death with the Maryland

Examiner Physician/Medical þ Completed

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Certification:

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that the death certificeta be axecuted physician est the burial Records, P.O. Box 68760 88 esn 0 signed by t We After Division death.

To the Hospital or Attend within 24 hours after death To the Funeral Director: A complataly filled in by the f

State

29b. Signature and title addrass of person who completed causa of death (Item 23a) (Type, Print)

5 Panding invastigation

6 ☐ Could not be

5714 Harford Road 482 Bookwidson

28a. Placa of injury - At homa, farm, streat, factory, offica building, atc. (Spacify)

29c. Licansa number D08388

Certifying Physicians: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The digital Examiners on the basis of examination and/or investigation in my calculated death.

1 Yas 2 No

On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Pay, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Baltimore, Maryland21214

Registrar

Luis E. Rivera, M.D.

1 DNatural

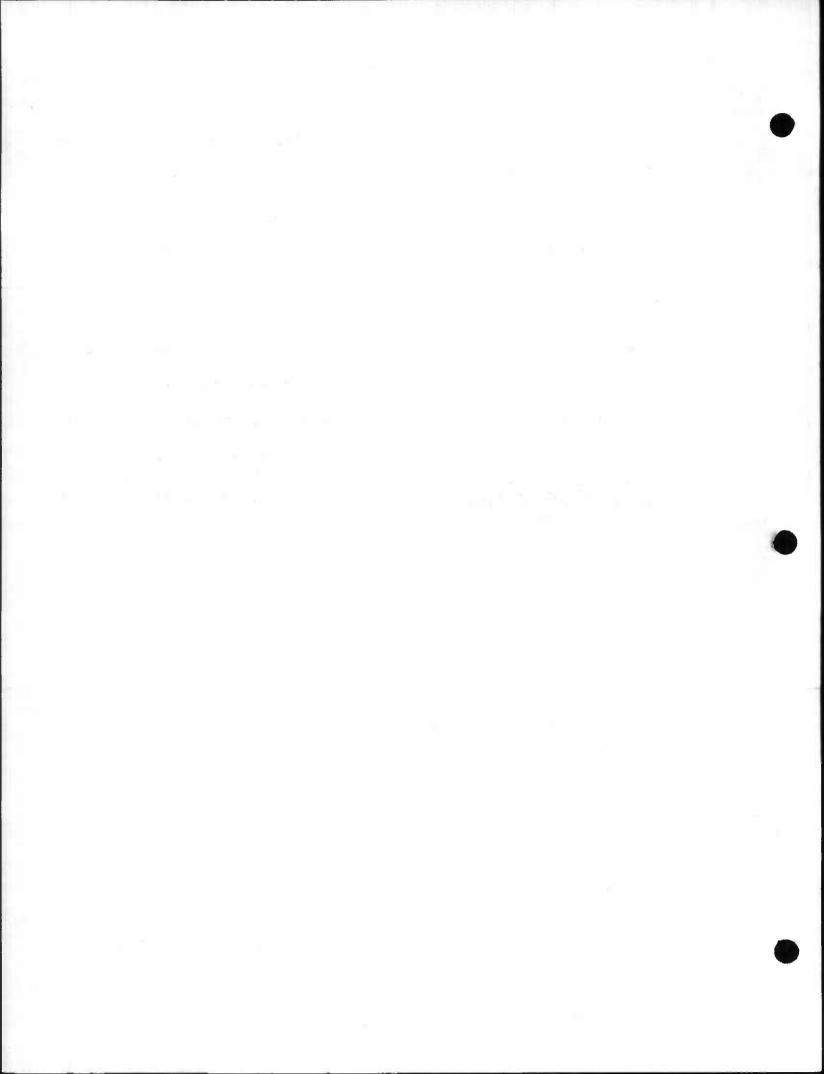
2 Accidant 3 Suicida

4 ☐ Homicida

29a Certifier

Make relations for

-			Decedent's Name (First, Middle		- Iviai yiaila		tificate of		Mental Hy	Reg. No.	97	08085
	ysicia Medic		0	Carey					2. Date of De Month Mar 1	7 1997	Yaar	3. Time of Death 8:42 A.M
	amin		4a. Facility Neme (If not institution Knollwood Ma			nter			or Location of Deat	,		
Fun Dire	ieral ctor		5. Social Security Number 219-016805		7. Aga (In yrs. las		If Under 1 Year Months Days		rs. 8. Date of Bir n. (Month, Da	th		undel place (Stata or Foraign ntry)
Maryland f show	led at	or	Usuel Residence of Decedent 10a. State 10b. County MD Anne	Arundel		Town or Loc						10d. Insida City Limits 1 ☐ Yes ※☐ No
th with the 23e or 28e	at be notified at	al Director	10e. Street and Number 1224 Annapo	lis Road			10f. Zip Code 2 1 1 1	3		10g. Citizen of V	What Cou	niry?
020 urs efter deal	Xaniner na	by Funeral	11. Maritai Status 1 Never Married 2 Married 3 XM2dowed 4 Divorced	Armed For	3 c☐ No		las Decedent of H Yes, specify Cub ☐ Yes X☐ No		(Specify Yas or No arto Rican, etc.)		ce - Amarick, White,	
Maryland 21215-0020 d 2 should be filed within 72 hours efter death with the Maryland in end Mental Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show	the Me	Completed	15. Deceden (Specify only higha: Elementary/Secondary (0-12) 12th	t's Education at grada complated) College (1-	-4or 5+)	_	ent's Usual Occup ind of work dona ONOT usa retire etary	oation during most of w d)	vorking	Gove		
5 8 E 6	200	To Be C	17. Fether's Name (First, Middla, Richard D.]						ame (First, Middle L. Mul		na)	
Mar d 2 sho th end 7 is me			19a. Informant's Name/Relations Doreen Care						Rural Routa Numb			
or Heal			20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cremetion	3 Ramovai from S		e of Dispos	ition (Nama of atory or othar pla	ca)	Date	20c. Location -	City or To	own, Stata
Baltimo	any injury once.		4 Donation 5 Dother (Specify) Nichols Bethel Cemetery 9 Odenton, 21. Signature of Funeral Service Licansea 22. Name and Addrass of Facility Hardesty Funeral 12. Ridgely Ave., Annapolis, M.									
Physical Median Examination Physical Ph	ical Iner	Examiner	23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Finel disease or condition resulting in death)	0	Rente Due to (or a pne	s a fonseque	lumar enca of):			irast,		Approximate Interval Between Onset and Death 2 - 3 occy 2 - 1 occy
	es the bur	edical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	Due to (or as						1	
P.O. nat tha de	se detached f	by Physician/M	Part II. Other significant condition Respire to	failure	ath but not resulting	ng in the uni	derlying cause give	ven in Pert I.		tobacco usa co Yee 2□ No	ntributa to	o the cause of death? bebly 4 Tunknown
aw requir	e 2 should I	Completed	heart	failu	-			0	24a. Was	an autopsy ormed?	av	ere autopsy findings railable prior to impletion of causa death?
= F 6	or, page	Be Co	25. Wes case referred to medical					26 Place of D	eath (Check only	Yes 2 DrNo	1 (☐ Yas 2☐ No
color V	90	္	examinar? 1 ☐ Yes 2 ☐ No			VOutpatient	3 DOA Oth	ner: 4 Nursing	Home 5 Resi	- 4-	er (Specil	(y)
Division Of the Control of the Contr	ed in by The face	Certification:	27. Menner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pendin Investig 6 Could determ	not be 28e. Piaca o	of Injury - At home g, etc. (Specify)	3b. Time of Injury		y at rk? Yes 2 □ No		how Injury occur Streat end Numb wn, State)		al Routa Number,
5 4 5	pletaly fill	edicai	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the base Examinar: On the base and manner	sis of examination	dge, death and/or inve	occurred et the tirestigetion, in my o	ne, dete and pla pinion, deeth oc	ce, and due to the curred at the time,	cause(a) and ma date and place,	anner as s and due to	tated. o the causa(s)
To the within To the	Coo	2	29b. Signature and title of certifier	hafthen	ZIM, F.	>	29c. Licens	ALCO	702	29d. Date signe	d (Month)	Day, Yaar)
	Stat		30. Name and eddress of person 10 HSic Hlux 31. Date flied (Month, Day, Yaar)	f MO	of deeth (Item 23	Crain	Hwy.	SW. #	f G1	en Bur	ni e,	Hd, 21061



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If Undar 1 Yaar

Deys

Physician /Medical Examiner

Funeral Director

the Meryland 7 is marked other than "nature!", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at with

 Hospital or Attendi
 Yat hours after death
 Funeral Director: A To the Hospital completely filled

Examiner Examiner physician and the burial-transit Box 68760 Physician/Medical 98 use ò ed by the a Records, P.O. þ Completed Deen aw. ğ Be 2 Certification: Medical

Physician /Medical diabete S 25. Wes case referred to medical

tred Louis 5. Social Security Number 242-38-5852 Usual Rasidance of Decedant 10a. Steta 10b. County Directo 10e. Streat and Number Funeral 11 Meritel Stetus 1 ☐ Never Married 2X Married þ 3 Widowed 4 Divorced Completed Elementery/Secondary (0-12) 8 17. Fether's Neme (First, Middle, Last) Thomas 21. Signature of Euneral Service Lice immediete Ceuse (Finel disaasa or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last

1. Decedent's Nema (First, Middla, Last) Canter 4a. Facility Neme (If not institution, give street end number) lohus Hopkins Bayvius 6. Sex 7. Aga (In yrs. last birthdey) 1□ M 2□ F 73 Yrs. Maryland Baltimore Dundalk 239 Ashwood Road 12. Was Decedent Ever In U.S. Armed Forcas? 1 Dayes 2 Na 6/9/40 If Yes, Give Yaar or Detes: 12/7/45 15. Decedent's Education (Specify only highest grada completed) College (1-4or 5+) NA Jefferson Canter 19e. Informent's Neme/Reletionship (Type, Print) Virgina D. Canter 20e. Method of Disposition

1 Burial 2 Teremation 3 Remove from Stata 4 ☐ Donetion 5 ☐ Other (Specify)

8. Dete of Birth (Month, Day, Feb. 9 9. Birthpleca (Stata or Foreign Country) N. Carolina Months T924 Feb. N. 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 21222 U.S.A. 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 ☐ Yas 2 XNo Specify: White 16e. Decedent's Usuei Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Machine Operator Bottle Cap Manufactu 18. Mother's Neme (First, Middla, Meidan Sumeme) Zollia Yates 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 239 Ashwood Rd. Dundalk, Maryland 21222 20b. Plece of Disposition (Neme of camatery, crematory or other pleca) 20c. Location - City or Town, Stete Metro Crematory, Inc. March18 Baltimore, Md. 22. Name end Address of Facility
W. Dabrowski/Chojnacki F.H. P.A. Enter tha disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. 1005 Dundalk Ave. Balto., Approximete interval Between Onset end Deeth

4b. City, Town, or Location of Death

Baltimere

If Undar 24 Hrs.

Hours

artery disease

hypertension

hyperlipidemia Dua to (or as a consequanca of):

Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i.

23b. Did tobacco use contribute to the cause of death? 1 PYss 2 No 3 Probably 4 Unknown

24a. Wes en eutopsy performed?

24b. Were autopsy findings available prior to completion of cause of deeth?

29d. Data signed (Month, Dey, Year)

2 No 26. Place of Deeth (Check only one)

1 Yes 2 No

2:54PW

4c. County of Death

NA

Hospitel: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Other (Specify) 1 Yes 2 No 28a. Date of injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturei 5 Pending

1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be 3 Sulcida 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

29e. Certifier 1 Decrifying Physician: To the best of my knowledge, deeth occurred et the time, date end pieca, end due to the cause(s) end menner as stated. (Check only one) 2 Medical Examiner: On the basis of axaminetion and/or investigetion, in my opinion, deeth occurred at the time, date and pieca, and due to the cause(s) end manner steted.

leanur

29b. Signature and title of certifiar

31. Date filed (Month, Dey, Year)

Ichard Chen, our

MAR 18 1997

30-Name and address of person who completed cause of deeth (ttem 23e) (Type, Print) 212 Dundack Ave. Baltimore, 40 21222

29c. License number

D47720

State Registrar

Registrer's Gignature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item 11 4-10-97 FilmG746 W.H.Per F/H Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** Nicholas Chudolin 7:45 PM March /Medical 4e. Fecility Neme (If not institution, give street end number, 4b. City, Town, or Location of Deeth Examiner 4c. County of Deeth Johns Hopkins Hospital Baltimore Cit N/A If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** M 2□ F Months 195-36-9031 Yrs. Director 50 May 1, 1946 Germany Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 23a or 28a-f show 10d. Inside City Limits the Medical Examiner naut be notified at PA Director Lehigh Whitehall 1 X Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1031 Catasauqua Rd. 18052 USA death Funeral Herns 11. Maritei Status 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 2 Married within 72 hours after % Yes 2 No If Yes, Give Year or DetesVietnam Baltimore, Maryland 21215-0020 6 1 ☐ Yes 2 X No Specify: ð Specify: 3 ☐ Widowed 4 ☑ Divorced natural', White Be Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 4 Bus Driver Transportation 17. Father's Neme (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item Z7 is marked oth any finjury or other traumatic event 2016s. 18. Mother's Name (First, Middle, Maiden Sumame) Serge Chudolij Anna Revyne 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Eva Chudolij 1031 Catasaugua Rd., Whitehall, PA 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete St. Andrew's Ukr.Orth. 3/20/97 South Bound Brook, NJ 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility ALTENBURG FUNERAL HOME, P.A. art. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or hear failute. Approximete Intervel Between Onset end Death **Physician** Immediete Ceuse (Finel disease or condition resulting in deeth) /Medical Septic Shock **Examiner** Physician/Medical Examiner Renal Failure the burial-tran Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that injured events.) Box 68760. Bone Marrow Transplantation The law requires that the death certificate be thet initiated events resulting in deeth) Lest Due to (or es e consequence ot) Refractory Acute Myeloid Leukemia P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Veno-Occlusive Disease Records, 24e. Wes en eutopsy performed? 24b. Were eutopsy tindings eveileble prior to Completed completion of cause of deeth? 1 Yes of Vital Be 25. Wes case reterred to medical 26. Plece of Deeth (Check only one) Hospital: 1 Impatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 27. Menner of Deet! 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how Injury occurred ivision 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Sulcide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, dete end placa, end due to the cause(s) end menner steted. 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 17, 1997 MO W9065 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Baltimore, MD

State Registrar

MAR 1 8 1997

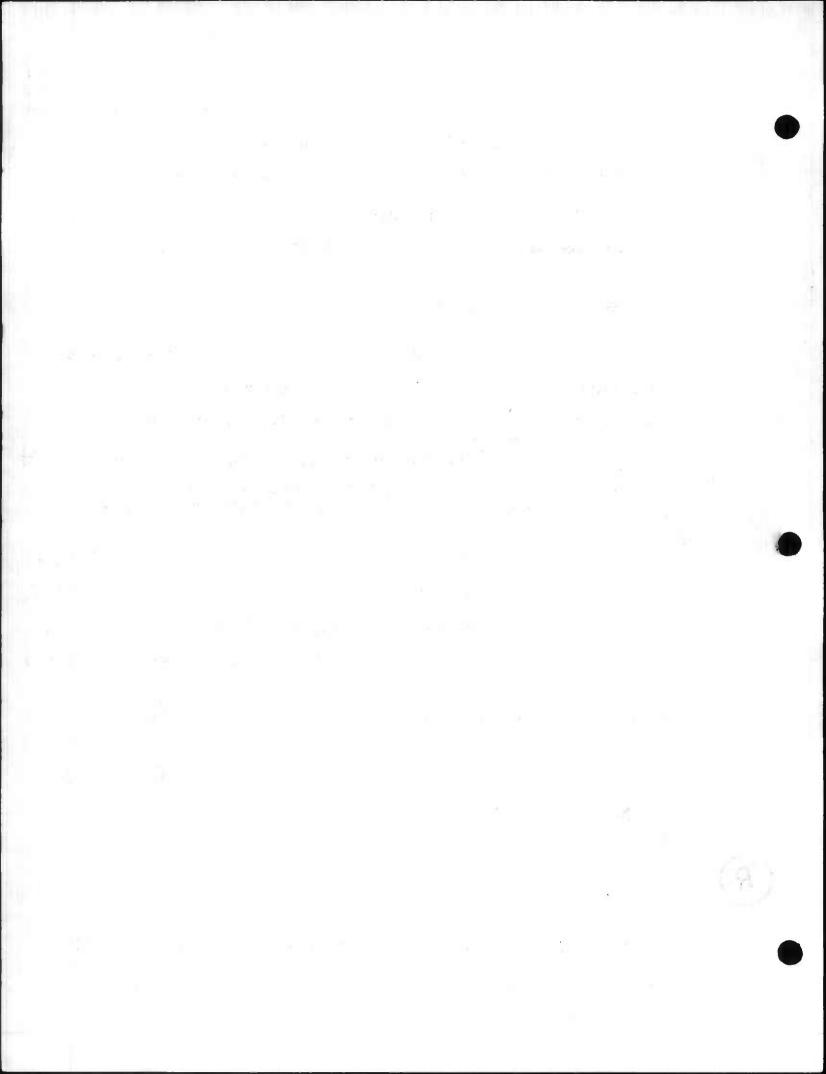
31. Dete filed (Month, Dey, Year)

Chin Hur

328 Registraris Signeture Julia Davidson Randalle

Johns Hopkohs Hosp.

21287



asp State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth CARTER Month JOHN STEVEN **Physician** 06 1997 MARCH 2215 P /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MONTGOMERY SILVER SPRING GEORGIA AVE If Under 24 Hrs. 8. Dete of Birth (Month, Day, If Under 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthdey) Funeral Birthplaca (Stata or Foreign Country) Deys 1**√** M 2□ F Months 37 Director 331-60-0289 Feb. 2, 1960 Indiana Usuel Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notined at 10d. Inside City Limits Yas 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8715 First Avenue U.S.A. 20910 Funeral death 12. Was Decedent Ever in U,S.

Armed Forces?

1 XYes 2 □ No

If Yes, Give 1994 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indien. Bleck, White, etc. filed within 72 hours effer Hygiene. Wher than "naturel", or ite 1 Nevar Merried 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: 1994 Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Yeer or Detas: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry MVM Elementery/Secondery (0-12) College (1-4or 5+) Project Manager Security permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked othe any injury or other traumatic event once. 17. Fether's Neme (First, Middle, Last) 18. Mother's Nema (First, Middla, Maiden Sumeme) Be Clyde W. Carter Joyce D. Rider 0 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Clyde Carter 205 S. Stewart Rd. #90 Mission, Texas 78572 Father 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetery or other place) Dete 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Quantico National 3/12/97 Triangle, VA 21. Signature of Funerel 22. Nama and Address of Fecility Mountcastle Funeral Home 13318 Occoquan Rd. Woodbridge, VA 22191 23a. Part1. Enter the disaase, or complications that caused the deeth. Do not anter the mode of dying, such es cerdiac or respiratory arrest, shock, or heert feilure. List only one ceuse on each lina. Approximate Intervel Between Onset and Deeth **Physician** /Medical mmediete Ceuse (Final disaesa or condition resulting in death) Carbon Monoxide Intoxication Examiner Due to (or es e consequence of) Examiner and the burial-tran Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury Dua to (or es e consequence of) Records, P.O. Box 68760, attending physician for use es the buria certificate be Physician/Medical thet initieted events resulting in deeth) Lest Dua to (or es e consequence of) USB 85 Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. deteched 23b. Did tobacco usa contribute to the cause of death? the 1 Yes 2 No 3 Probably 4 Unknown þ 8 24b. Were autopsy findings available prior to 24e. Wes en eutopsy Completed performed' completion of cause of death? À ate hes DB06 2 å 128 Yes 2 No 1 TYas 2 No of Vital Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence Whether (Specify) SCENE 10 1 XYes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Certification: 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Naturel Injury 1 Yes 2MNo 2 Accident Found 3-6-97 UNITHOWN For Attended to the organization of the organi Subject inhaled car exhaust 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, State) \$715 | S + aveny 3 4 Homicide Public Parting Garage Silver Spring, Many Land

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and plece, end due to the cause(s) and manner as stated.

2 Medical Examtner: On the best of examination and/or investigation, in my opinion, death occurred at the time, dete end pleca, and due to the cause(s) end manner steted. To the Hospital of within 24 hours of To the Funeral D completely filled it Maryland Medical (Check only one) 29b. Signeture end title of certifiar 29d. Date signed (Month, Day, Year) MARCH 07, 1997 29c. License number O.C.M.E

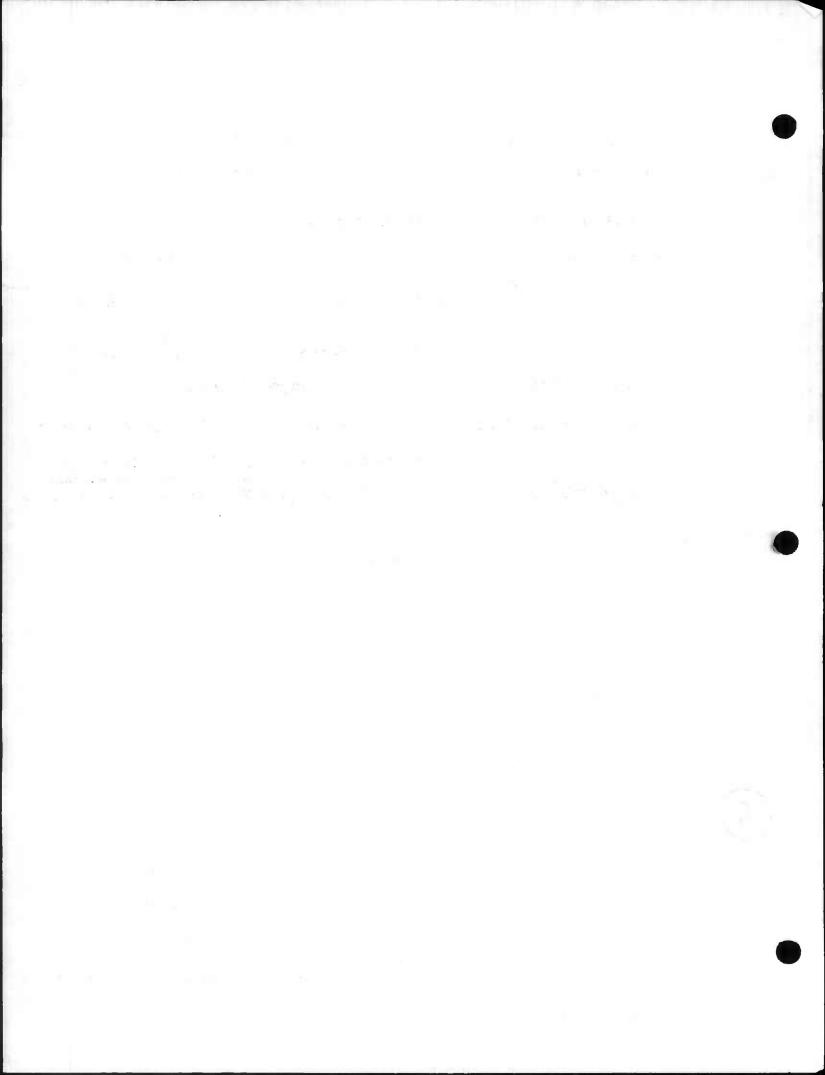
111 Penn Street, Baltimore, Maryland 21201

State Registrar Stephen S, 1.
31. Dete filed (Month, Day, Year)

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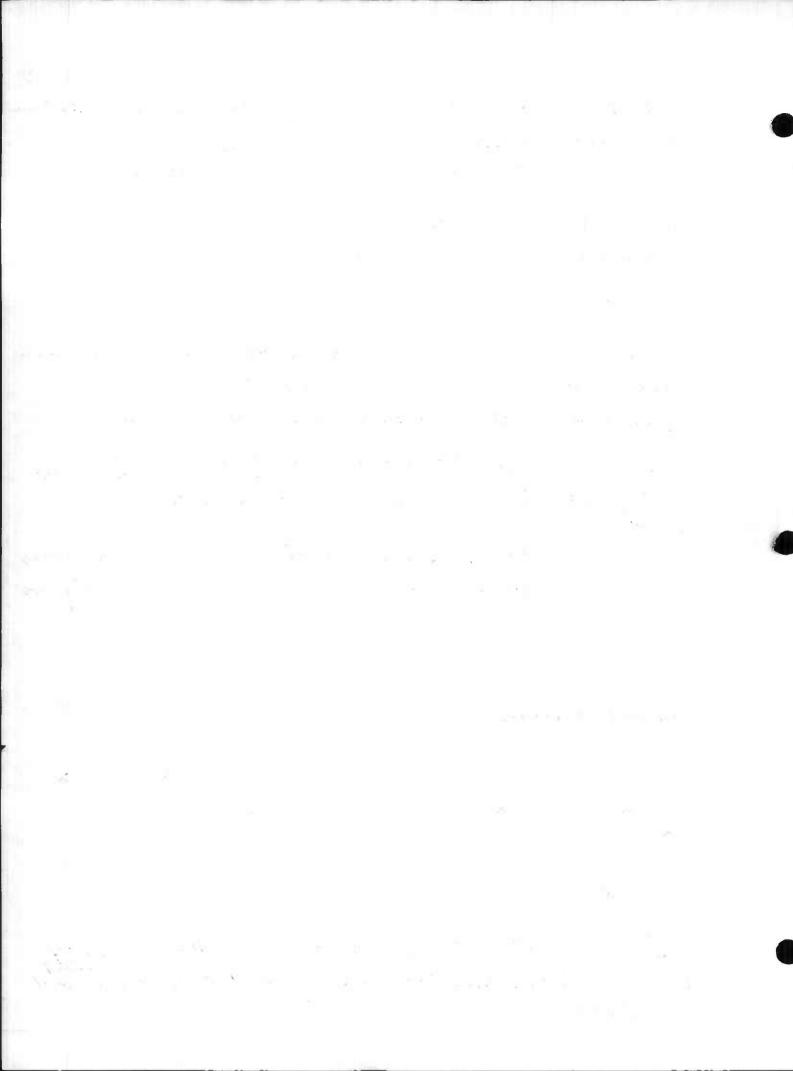
30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) S. Radenyz, MO

32. Registrar's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	Reg.	0.7	08089	
	Physic		1. Decedant's Nama (First, Middla, Last) Vickie Lynn Collins	2. Data of Death Month	Day Yaar	3. Tima of Death	
	/Medi Exami				15 1997 4c. County of Death	12:50 An	
15	LAGIIII	ICI	THE TOUNG HODITUG HOSPITA				
	Funeral		5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hr.	S. B. Data of Birth	9. Birth	place (Stata or Foreign	
	Director		214-72-5077 1□ M 2⊠ F 37 Yrs. Months Days Hours Min	July 27,1	959 Balt:	imore, MD.	
	the Maryland 28a-f show	١	10a. Stata 10b. County 10c. City, Town or Location			10d. Insida City Limits 1 □ Yas 2 ☑ No	
	he M	Director	MD Baltimore Owings Mills				
	E 6 8	늅	10e. Street and Number 10f. Zip Coda	10g.	Citizan of What Cour	ntry?	
	a 23	eral	9425 Georgian Way 21117		USA		
21215-0020	within 72 hours efter death with the Maryland ene. than "natural", or itema 23e or 28e-f show he Medical Examinet must be notified at	by Funeral	If Yas, Giva 1 ☐ Yas 2 ☑ No Specify: Year or Datas:	Specify Yes of No- rto Rican, atc.)	14. Race - Americ Black, Whita, Specify: Whi	atc.	
0	72 ho	Completed	15. Decedant's Education 16a. Decedant's Usual Occupation	16b.	. Kind of Business/In	dustry	
2	within 72 ho jiene. r than "natur me Medical.	ple	(Spacify only highest grada complated) (Giva kind of work dona during most of work dona during	orking			
CA	many from the latest t	Son	12 2 Computer Systems Analy	st So	cial Secu	rity Admin.	
Maryland	d oth	Be (nme (First, Middle, Maid	lan Sumama)		
N N	should be filed and Mentai Hygia marked other urmatic event, II	2	Eugene Belcher Mary Sh	nell			
a	and and is me		19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Relationship)			Code)	
			Eugene Belcher (Father) 3 Duralumin Court Ba	altimore, M	D. 21220		
Baltimore,	0 = 5		20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata Donation 5 Other (Spacify) 20b. Placa of Disposition (Nama of comatary, cramatory or other place) Hilltop Service Corp.		. Location - City or To OWSON, MD		
Balt	permit. Pa Departmen important eny injury		1 / / / / / / / / / / / / / / / / / / /	Ruck Towson		Home, Inc.	
		П	23a. Part 1. Enter tha diseasa, or complications that causad tha death. Do not antar tha mode of dying, such as cardie shock, or heart failure. List only one cause on each line.		T	Approximata Intarval Batween	
	Physician Examiner	ner	Immediata Causa (Finel diseasa or condition resulting in death) a. Abuse to (or as a consequence of):		1	Conset and Deeth lo menths	
	saft certificate be executed ettending physician end for use es the bunel-transit	in/Medical Examiner	Sequantially list conditions, if any, laading to immediate causa. Entar Underlying Causa (Disaasa or injury that initiated avents rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
מ	death e ette vd for	sicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23h Did tohac	co use contribute to	o the cause of death?	
. P.	es that the de igned by the be deteched	by Physician/W	Liver Metastanis			bebly 45Unknown	
Hecords,	aw requir	Completed b		24a. Was an au performed	? av	ara autopsy findings allable prior to mplation of causa daath?	
= '	Dag at	S		1□ Yes	2 No 1	Yas 2NHo	
VITAI	ysician: In s certificate director, pa	Be	axaminar?	eath (Check only ona)			
0	Physician: this certific ral director,	2		Homa 5 ☐ Rasidance		y)	
	Attending P or death.	Certification:	27. Manner of Death 1		28d. Dascribe how Injury occurred		
2	Hospital or At 24 hours effer of Funerel Directely filled in by	Certif	4 ☐ Homlcida 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)	28f. Location (Straat City or Town, St		u Houta Number,	
	To the Hospital of Attanding is within 24 hours siter death. To the Funertel Director: After completely filled in by the funer	edicai	29a. Cartiflar (Check only one) Cartifying Physician: To the bast of my knowledge, daath occurred at tha tima, data and place and place of examiner: On the basts of examinetion end/or invastigation, in my opinion, deeth occurred at tha tima, data and place of examiner: On the bast of my knowledge, daath occurred at tha tima, data and place of examiner: On the bast of my knowledge, daath occurred at tha tima, data and place of examiner: On the bast of my knowledge, daath occurred at tha tima, data and place of examiner: On the bast of my knowledge, daath occurred at tha tima, data and place of examiner: On the bast of my knowledge, daath occurred at tha tima, data and place of examiner: On the bast of examiner:	e, and due to tha causa urred at tha tima, date e	(s) and menner es s and plece, end dua to	tated. o tha cause(s)	
	vithin 2 To the	Σ	29b. Signature and titla of certifiar 29c. Licansa number		Data signed (Month,		
			Dennem Calkin his RESONA	Ma	March 15, 1997		
	10		Dever Collection D. RES 006 30. Nema and eddress of person who complated cause of deeth (Item 23a) (Type, Print) BEVER L. M. Colkins M. D. 600 North Wolfe Scripting and the state of the	est Back	more, /	21287	
	Sta Registr		31. Deta filed (Month, Day, Year) MAR 18 1997 Selection Author Control of the C				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Items10c,11 3-18-97 FilmG745 W.H. Per Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dev **Physician** Month Year MARCH 13, /Medicai JAMES CORNIAS 1997 6:00PM-4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON
Scolal Servicity Number 6 Sex 7. Age (In vrs. last birthday) II Under 1 Yeer If Under 24 Hrs. BALTIMORE 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funerai Birthplece (State or Foreign Country) Deys 10XM 2□ F Months Hours 077-24-7600 66 Yrs Director 02/08/1931 Greece Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show 10d. tnside City Limits Parkville Md Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1251 Deanwood Road 21234 United States Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 11. Maritel Status filed within 72 hours efter 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1□ Yes 2☑No Completed by 3 Widowed Specify: Co 447 Divorced Pages 1 and 2 should be filed within 72 homen of Heelth end Mental Hygiene.
snt: if Item 27 Is marked other than "naturary or other traumatic event, the Medical Decedent's Usual Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 18b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) 5 + Elementery/Secondery (0-12) 211 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Konstantinos D. Cornias Anthoula Pikounis 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Gus J. Cornias 127 Arbutus Avenue Catonsville, Md. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State
4 Donetion 5 MOther (Specify) Entonoment Department of Important: If any Injury or Moreland Memorial Park 3/17/97 Baltimore, Maryland 21. Signeture of Funerel Servica Licansee Mark T. 22. Name and Address of Facility
Leonard J. Ruck, Inc. Zavoyna Mark T. 5305 Harford Road Baltimore, Maryland 23e. Pert1. Enter the disease, of compilirations that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or hear feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical tmmediete Ceuse (Fine) disease or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed for use as the burial-transit pul Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequença of) P.O. Box 68760, Due to (or es e consequenca of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yee 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records q 2 24b. Were eutopsy findings avelleble prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 1990 99 2 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Wes case referred to medical 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2□-No 1⊠Inpatient 2□ ER/Outpatient 3□ DOA 27. Menner of Deeth 28e. Dete of injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1. Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident after death death 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) B 4 Homicide 1 Certifying Phyeictan: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner stated. Medicai 29e. Certifier (Check only

To the Hospital of within 24 hours at To the Funeral Dicompletely filled in

State Registra

31. Dete filed (Month, Day, Year) MAR 18 1997

29b. Signeture end title of cartifier

6701 N. Charles Street John Covington, M.D. 32. Registrace Signeture ina Landson Pandelle

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

29c. License number

DHMH 16 Rev 6/95

Towson, Maryland

29d. Dete signed (Month, Dey, Year)

21204

Primary and Sept of 1 Sept

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth JORMAN MARCH SISNE 11.03am 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Lorien Nursing Center Columbia Howard 5. Social Security Number If Under 1 Year Under 24 Hrs. Hours Min. 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dev. Year) 9. Birthplece (State or Foreign Country) Days 10km 20 F Yrs 220-16-5239 70 Aug. 4, 1926 Maryland Usuel Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside Cify Limits 1 ☐ Yes 2 ☐ No Maryland Anne Arundel Severn 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 1237 Old Camp Meade Road 21144 United States 11. Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □XYes 2 □ No If Yes, Give Year or Detes: 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WWII White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Classified Employee Federal Government 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surneme) Norman H. Disney Marian L. Clark 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Charlotte E. Disney/Wife 1237 Old CAmp Meade Rd. Severn, MD 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Friendship Cemetery March 18, 1997 Hanover, MD 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility Kirkley-Ruddick Funeral Home bawa 421 Crain Hwy. S.E. Glen Burnie, MD 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) ARR: HYTHMIA Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 100 3 Probably 4 Unknown 24b. Were eutopsy tindings aveileble prior to completion of cause of deeth? 24e. Wes en autopsy performed? 1 Yes 25 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

10e Stete

Director

by

Be Completed

2

Funeral

Director

r than "natural", or items 23a or 28a-f show The Medical Examinar must be notified at

the Maryland

death with

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiane.

item 27 is marked other other traumatic event,

Department of Health ar Important: If Item 27 Ia any Injury or other trau

Baltimore, Maryland 21215-0020

bunial-tren attending physician use es the ò the

The death certificate be executed Physician/Medical certificata has or Attending Physician: The Be 2 this Certification: After

Division of Vital Records, P.O. Box 68760,

s after deau...al Director: After To the Hospital o within 24 hours at To the Funeral Di Medical

31. Dete filed (Month, Dey, Year) State Registrar

MAR 1 8 1997

1 Yes 2 No

5 Pending Investigation

6 Could not be determined

27. Menner of Deeth

Maturel

2 Accident

3 ☐ Sulcide

4 Homicide

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) end menner stated. 29b. Signeture end title of certifies

29c. License number

1 Yes 2 No

29d. Dete signed (Month, Dev. Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

cun 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

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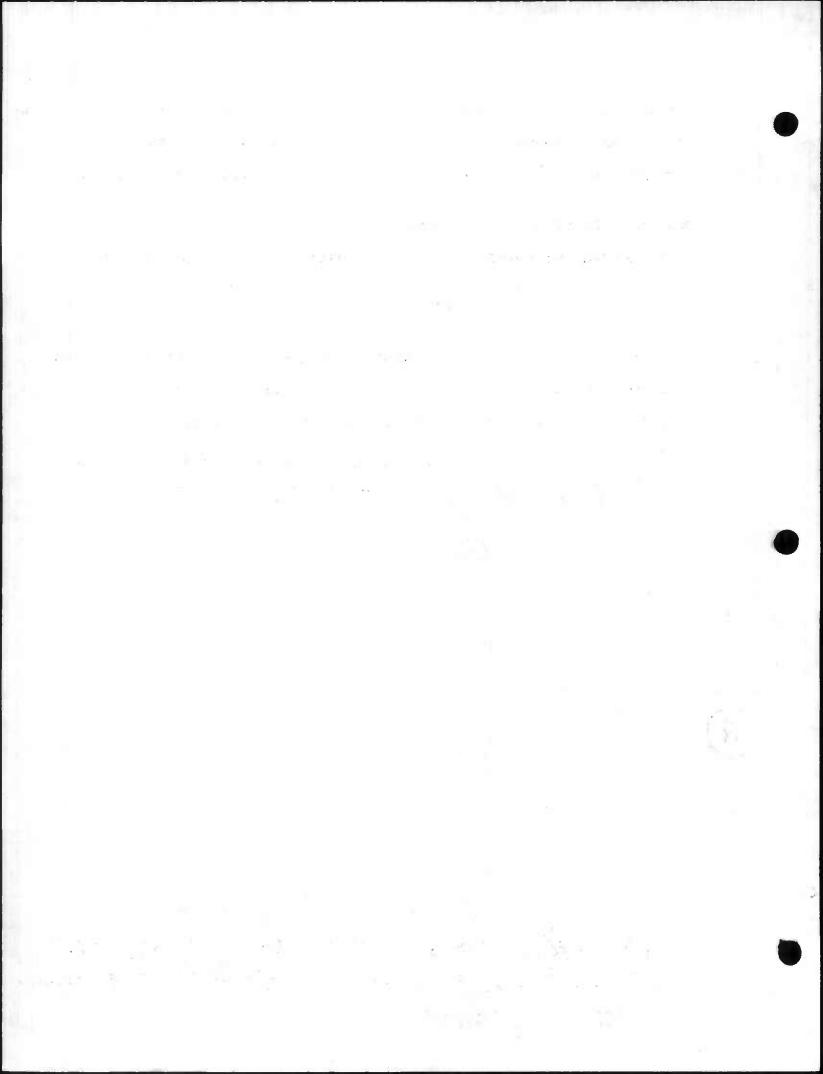
32. Registrer's Signeture

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month JACQUE DANIELS MARCH 18:05 P 12, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth **Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpiace (State or Foreign Country) **Funeral** Months Yrs. Director 213-32-9847 60 September 7,1936 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show items 23a or 28a-f ehov 1 Yes 2 □ No Director Maryland N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours efter death with 1313 Demarcy Way Funeral 21224 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 [X] Yes 2 □ No If Yes, Give Year or Dates:1959–1961 11. Maritai Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Biack, White, etc. The Medical Examiner 1 Never Married 2 Married 21215-0020 ò 1 Yes 2 No Specify: þ 3 Ø Widowed 4 □ Divorced Specify: White natural, Completed 15. Decedent's Education 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Customer Service Representative Baltimore Gas and Electric traumatic event. Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ie marked ot Be Peges 1 and 2 should be family of Health end Mental Gertrude Louise Davis William Marshall Daniels 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 s Department of Health er Important: if Item 27 ie any Injury or other trau Mrs. Gertrude L. Daniels / Mother 1900 Burnwood Road Baltimore, MD 21239 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 3/15/97 Elkridge, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5305 Harrford Road Leonard J. Ruck Funeral Home, Inc. Baltimore, MD 21214 Marke T. 23e. Part 1. Enter the disease and accomplications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. **Physician** /Medical Immediate Cause (Final Respiratory Arrest disease or condition resulting in deeth) 1 minute **Examiner** Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a consequence of): P.O. Box 68760. Biliary Obstruction
Due to (or as a consequence of): attending physician Physician/Medical Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? COPD - chronic abstractive Pulmanay disease 1 Yes 2 No 3 Probably 4 Unknown vision of Vital Records, Be Completed by 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24e. Wes an autopsy performed? Diabetes Hypertension 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Physician; 25. Was cese referred to medical 26. Place of Death (Check only one) Hospitel: 1 Minpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) Medicai Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and piace, end due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a, Certifier within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 16ll Riddling MD March 12, 1997 RES-000

State Registrar 31. Dete filed (Month, Day, Year)

MAR 18 1997

Holly R Dahlman, MD

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print)

33. Registrar's Signature

The Johns Hopkins Hospital, Tower 110

Balt, MD

Total s Y ... II

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 1997 ear 17, Day March 9:30 AM Julia Mary Dousa 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth N/A Baltimore Lorien Nursing Home - Frankford If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. (Month, Day, 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Deys Year) 1 ☐ M 2 🕅 F Yrs 212-05-7940 February 1, 85 Maryland Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2□No N/A Baltimore Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6414 Marietta 21214 United States Avenue 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Raca - American Indien Bieck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritei Stetus 1 Never Merried 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Ø Widowed 4 □ Divorced 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Hame 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Elizabeth Hirt Thomas Petr 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Pauline M. Rebbert / Cousin 6414 Marietta Avenue Baltimore, MD 21214 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece, 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 3/20/97 Most Holy Redeemer Cemetery Baltimore, Maryland 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility Leonard J. Ruck, Inc. marke 5305 Harford Road Baltimore, MD one cause on each line. Approximate Interval Between Onset and Death 23a. Pert1. Enter the diseese, or shock, or heert feilure. List of immediate Cause (Final disease or condition resulting in deeth) Due to (or as a consequence of) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? Other/significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 NO 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 28. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA 27. Menger of Deeth 28a. Dete of injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. injury at Work?

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ral', or items 23a or 28a-f show

Peges 1 and 2 should be filed within 72 hours efter one of Health and Mental Hygiene.
Int: If tem 27 Is marked other than "natural", or Itel into other traumatic event, Ire Medical Experiently or other traumatic event, Ire Medical Experient.

permit. Pege Department of Important: If any injury or once.

Physician /Medical

Baltimore, Maryland 21215-0020

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law requires that the death certificate be executed P.O. Box 68760. d for use as t signed by the et d be detached for Records,

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To the Hospital o within 24 hours at To the Funeral Di completely filled is

Division

29b. Signeture epet litie of certifier

5 Pending

Investigation

6 Could not be

1 Neturei

2 Accident

4 Homicide

3 Suicide

29e. Certifier

Va

28e. Piece of fnjury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. License number

1 Yes

2 No

to certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end manner as stated. 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Mosth; Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) RE iRKi SMID, DRIC

7151 HOLABIRD AVE, BALTO, MS, 21222

31. Dete filed (Month, Dey, Year) MAR 18 1997 State Registrar



1 C 18 × 36

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Items: 5,18 per F.H. G-745 3/21/97 reb Certificate of Death 1. Decedant's Neme (First, Middle, Last) 2. Dete of Death **Physician** CRANK Henry KwaKu 1) UNYON /Medical 4b. City. Town, or Location of Death Examiner 4c. County of Death RANADA NUTSING If Under 1 Year If Under 24 Hrs. a Detection Home Sex 120 M 2□ F 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** 2/7-90-640 Usuel Rasidence of Decedent Deys Yrs. Director MANA 10e. Stete 10b County 10c. City, Town or Location 28a-f show 10d, Inside City Limits the Medical Examiner must be notified at 1 FYes 2 □ No Director MAry MM 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Pages 1 end 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
snt: If item 27 is merked other than "natural", or items 23a or any or other traumatic event, the Medical Examines must be 8 west ow/ON Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritei Status Reca - American Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married If Yas, Give Year or Detes: 1 Yas 2 PNo Specify: 9 3 ☐ Widowed 4 ☑ Divorcad richN Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) Elementery/Secondary (0-12) College (1-4or 5+) 12Th lurer 17. Father's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Symame) Be Johnson Dunyoh 19a. Informent's Name/Reletionship (Type, Print) (Brother) **GBEDEMAH** 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, HON Ave. Kobe 20e. Mathod of Disposition 20c. Location - City or Town, Stafe 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from Stete important: I any injury o □ Donetion 5 □ Other (Specify) Signeture of Funeral Servica Licensee disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiec fellure. List only one ceuse on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final re ctum diseese or condition resulting in death) ENMINA Cancer 3 moths Examiner Dua to (or as a consequence of) Physician/Medical Examiner me tasteuls the burial-transit Sequantially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Diseesa or Injury that Initieted evants resulting in death) Lest Due to (or as a consequence of): Chiente attending physician chstructive 154-5 Due to (or es e consequenca of) 88 oulstis Ulceratic 25423 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobecco uea contributa to the causa of death? 1 Yss 2 No 3 Probably 4 Unknown schizo phraid paraneld þ Completed 24b. Ware autopsy findings avellabla prior to complation of causa of deeth? 24a. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical exeminer? 26. Pleca of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

The law requires that the death certificate be executed P.O. Box 68760, Records. After this cartificate has Division of Vital ro the Hospital or Attending Physician: death

Saltimore, Maryland 21215-0020

filled in by the funeral director, page 2 should be within 24 hours after death To the Funeral Director: completely filled in by the

29a. Cartifier

27. Manner of Deeth 2 Accident 3 Suicide

5 Pending Investigation 4 Homicida

6 ☐ Could not be datarmined

Dete of Injury (Month, Day Year) 28b. Time of

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

Are

28d. Describe how Injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, State)

1 Cartifying Phyeictan: To the bast of my knowladge, deeth occurred et the time, dete end piece, and due to the ceusa(s) end menner es stated.
2 Madicat Examinar: On tha basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end piaca, end due to the ceusa(s) and menner steted. (Check only one) 29b. Signeture end title of cert 29c. License number

D 36494

29d. Date signed (Month, Day, Year) 3/17/97

30. Nema and address who complated causa of daath (Itam 23a) (Type, Print)

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4660 wiltons Balli nac MD XIZKA

State Registrar 31. Dete filed (Month, Day, Year) 32. Registrar's Signature MAR 18 1997

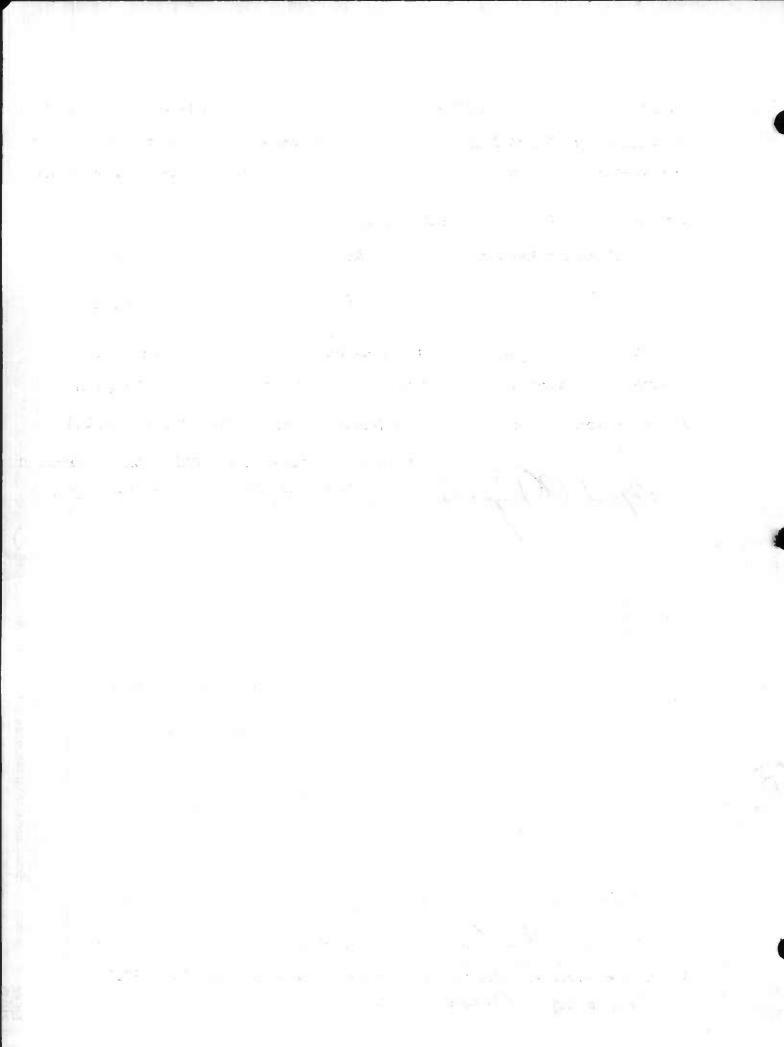
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					Certificate of	Death		Reg. No.	97	08095
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of the de sched	Physician	Part II. Other significant conditions of	ontributing to death but not re	sulting in	ha undarlying causa giv	van in Part I.	23b. Did	tobacco uae cor	ntribute to t	the cause of death?
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To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical	29a. Cartifiar 1 Certifying Ph	ysician: To the best of my kr ninar: On the basis of examinand manner stated.	nowledge, nation and/	death occurred at the tir or Invastigation, in my o	ne, data and p pinion, daath o	place, and dua to that occurrad at tha time,	ceuse(s) and ma data and place,	innar as sta and dua to t	ted. ha causa(s)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Funeral			. Sex	7. Age (In y	rs. lest birthday)			24 Hrs. 8.	Date of Birth		1	lece (Stet	e or Foreign
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	0	James Fr	ankli	in	Burto	n	Bet	tty			Tamp.	lon	
		19a. Informent's Neme/Reletionship	(Type, Print)	19b. Meili	ng Address (St	reet end Numbe	er or Rurel R	oute Number,				
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any injury or other traumatic event, the Magical once.		20a. Method of Disposition		20b	Piece of Dispo	sition (Neme o	oloop)		Date 2	20c. Location	- City or To	wn, Stete	
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		23a. Part1. Enter the disease, or co shock, or heart failure. List or	1 /K	omerci	k. 1	005 Du	ndalk	Ave.	Balt	- Md			
88		shock, or heart failure. List or	ly one ceuse	eech line.	eth. Do not ent	er the mode of	dying, such as	cardiac or re	espiratory arre	est,		Approxim interval B	ete etween
an al		Immediate Ceuse (Finel	/									Onset an	d Deeth
er		disease or condition resulting in deeth)	e He	patic en	cephalo	pathy						15 da	ys
	h.			Due to	(or es e consec	juenca of):							
П	Examine		b. En	d-stage	hepatic	failur	e				1		
	Xan	Sequentially list conditions, if eny, leeding to immediate		Due to	(or es e consec	uenca of):							
		cause. Enter Underlying Cause (Disease or Injury	. Lo	ngterm a	lcohal	abuse					1		
	edical	thet initieted events resulting in deeth) Last	0.		(or es e conseq								
se as the bunat-trar	Me												
			0										
	8	Pert II. Other significant conditions	contributing	to death but not re	sulting In the u	nderlying cause	given In Pert I.		23b. Did tol	bacco use co	ntribute to	the cause	of death?
	Physician								1 🗆 Ye	e 2⊠ No	3 Prob	ably 4[Unknown
	à										-		
								}	24e. Wes en	eutopsy		re eutopsy	
	Completed								periorii	1001	соп	npletion of	
	E								1 ☐ Ye	s 216 No			TAIC
		25. Wes case referred to medical	T					15			1	Yes 2[No
	o Be	exeminer? 1 ☐ Yes 2 ☒ No	Hospitel:	479714 41 4 44			Other:		heck only one				
	0	27. Manner of Deeth		1X Inpatient 2[Dete of Injury	ER/Outpetien 28b. Time of	1 3LI DOA	4LI NUI			nce 8 Oth)	
	Certification:	1 Netural 5 ☐ Pending	(1	Month, Dey Year)	Injury		njury et Work?		. Describe no	w Injury occur	red		
	8	2 Accident investiget 3 Suicide 6 Could not	he				Yes 2 N						
	Ē	4 ☐ Homlcide determine	d 289. P	flece of Injury - At uilding, etc. (Spec	home, term, str cify)	et, fectory, offi	Ce	281.	City or Town,	eet and Numb Stete)	er or Rural	Route Nu	mber,
	edicai	Check only 2 Medical Ex	hysician: To miner: On th	the best of my kn ne basis of examin	owledge, deeth	occurred at the	time, dete end	f plece, end	due to the ce	use(s) and me	end due to	eted.	(e)
	Med		end r	menner steted.						to one plood,	0110 000 10	uno causo	(0)
1	-	29b. Signeture end title of certifier	00	11		29c. Lice	ense number		29	d. Dete signe	d (Month, E	Dey, Year)	
Li.		Dr. Suzette	Chus	eller	0.0.	R D	2115			3/1:	3/97	7	
	1	30. Neme end address of person wh	completed (cause of deeth (Ite	em 23e) (Type,	Print)							
		Dr. Suzette Chan		9000 Fra			or. Balt	timore	, Mary	land 2	1237		
State	e	31. Date filed (Month, Dey, Yeer)	. 3	2/Registreds Sign		00.							
gistra		MAR 18 199	7 8	Tura verra	Direction of the	100 mg							

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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				_	_	

	Physic	ľan	1. Decedent's Name (F					imoate	01	Death		2. Dete of De Month	Dey	Yeer		me of Deeth
	/Medi Exami		4e. Facility Neme (If no	t Institution, giv	e street end nu		AWSON				wn, or Lo	March ocation of Deet		y of Deeth	111	:55 AM
			2832 Gu								timo			I/A		
Į,	Funeral Director		5. Sociel Security Number 219–12–891		Sex I□M 2√2 F	7. Age (In yrs. 71	last birthdey) Yrs.	Months [Yeer Deys	If Under a	Min.	8. Dete of Bir (Month, De Feb • 6	iy, Y27, 1926	9. Birth	plece (S ntry) Tan	tete or Foreig d
	De s		Usual Residence of De 10e. State 10	cedent b. County	-	10- 0	ty, Town or Lo									
	with the Maryland a or 28e-f show be not fied at	5	MD	N/A			Baltim									de City Limits Yes 2 ☐ No
	tha N	Director	10e. Street and Numbe				JOI CINK									1103 2[][[
	th with 23s or		2832 Guil		re.			10f. Zip Co	212	18			10g. Citizen of		ntry?	
020	72 hours after death with the Maryland natural, or Items 23s or 28s-f show picel Examiner must be not feed at	by Funeral	11. Maritel Stetus 1 Never Merried 3 Widowed 4		Armed F	ZX No		Wes Decedent If Yes, specify 1 ☐ Yes 2 ∑			gin? (Spo , Puerto	ecify Yes or No Rican, etc.)	14. Ra Ble Speci	ce - Americk, White,		
Maryland 21215-0020	within 72 hours ena. than "natural",	Be Completed	15. (Specify of Elementery/Saconda		de completed) Collaga ((1-4or 5+)	(Give	dent's Usuel C kind of work of DO NOT use	done retired	duning most	of work	ing	16b. Kind of E			
d 2	be filed with ital Hygiene. d other than event, the	ပိ	17. Fether's Name (Firs	t Middle Last	4_		School	ol Prin	ci		r'e Name	/First Middle	Baltimo		ity_	
ylan	2 should be filed within and Mental Hygiene. Is marked other than " surmatic event, the Men	To Be	George '										ella Lut			
Mar.	D 5 5 5		Forrest										er, City or Town		Code)	
Baltimore,	Pagas nent of ant: If it		20e. Method of Disposit 1 N Buriel 2 C 4 Donetlon 5 C	remetion 3 [sition (Neme metory or othe Burial			3,	Dete /17/97	20c. Location Balti			ite
Balt	Departr Departr Importa any Inje		21. Signature of Funers	Service Licer	etili.							OME, P.		2121	4	
	Physician /Medical Examiner		Immediate Ceusa (Finadisease or condition rasulting in deeth)		^	bable	h. Do not ent	er the mode o	of dyin	ng, such es	cardiec o	or respiretory a	rrest,		Approx	ximete il Between and Deeth
		je	,		1.1		or es e consec	quenca of):								
_6	axecuted n and ai-transit	Examiner	Sequentially list condition of the condi	ons,	b. 140	Due to (c	or es a consec	juence of):							T	
Box 68760,	th certificate be asscuted anding physician and r use as the burial-transit	an/Medical	Ceuse (Disaesa or Injur thet Initiated events resulting in deeth) Lest	⁹ 1	c. +1	Due to (o	res e conseq	uence of):								
Box	eath certif attanding I for usa a	ian/M			d											
P.O.	that the death ed by the atter deteched for	Physici	Pert fi. Other algnifican	t conditions of	ontributing to d	eath but not ras	uiting in the u	nderlying caus	se giv	en in Pert f.			tobacco use co			use of death
Boord	2 should be	Completed by	Barr	عساء	onis	Di	seen	e				24e. Wes	en eutopsy ormed?	av	eilebie [opsy findings prior to n of cause
×	Physician: The this cartificate had director, page	E										10	Yes 20 No	1 [Yes	2□ No
ita	delan: T cartificate rector, pa	Be	25. Wes case rafarred t exeminer?	o medical						26. Place	of Deeth	Check only	ona)			
of Vital	Physician: this cartific rai director	2	1 Yes 2 No		Hospitel: 1	Inpatiant 2	ER/Outpatien	t 3 DOA	Oth	ar: 4 🗆 Nur	rsing Ho	me 5 Resi	dence 6 □Ot	ner (Specil	fy)	
sion o	tending Pt Seath. tor: After the the funera		2 Accident	☐ Panding investigation	1	of Injury th, Day Year)	28b. Time of Injury	28c.	Injur Wor	yat k? Yes 2□N		28d. Describe	how injury occu	red		
Division	or Attand	Certification:	3 ☐ Suicide 6 4 ☐ Hornicide	Could not be datermined	286. Place	e of Injury - At he ing, etc. (Specif	ome, ferm, str	eet, factory, o	ffica			28f. Location (City or To	Street end Num wn, Stete)	ber or Run	al Route	Number,
	Hospital 24 hours a Funeral I	dical	29a. Certifier 1 (Check only one)	Certifying Phy Medical Exam	ifner: On the b	best of my kno asis of axamina	wledge, deeth tion and/or Inv	occurred et t vestigetion, in	ha tin	ne, dete end pinion, deet	d plece, o	end due to the ed et the time,	causa(s) end m date end place,	enner as s and due to	teted. o the ca	use(s)

29c. License number

242123

State Registrar

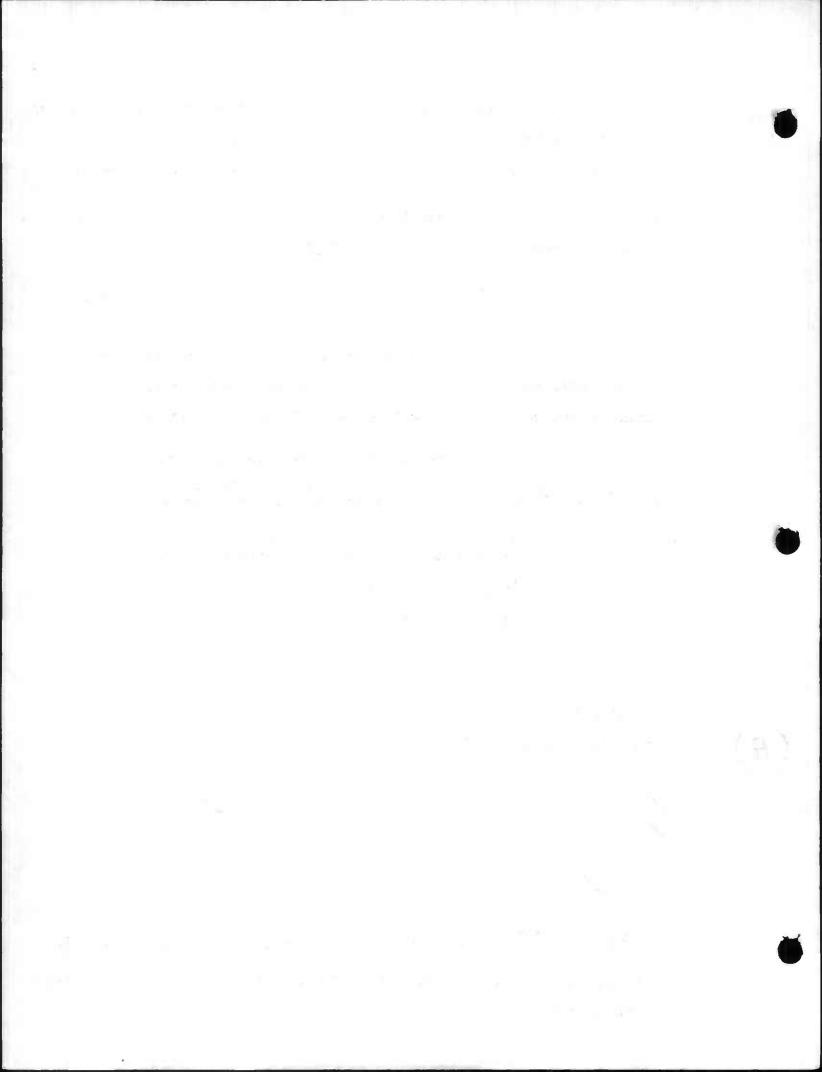
29b. Signeture end title of certifier

500 W. University 31. Dete filed (Month, Day, Year)

32. Ragistar's S MAR 18 1997

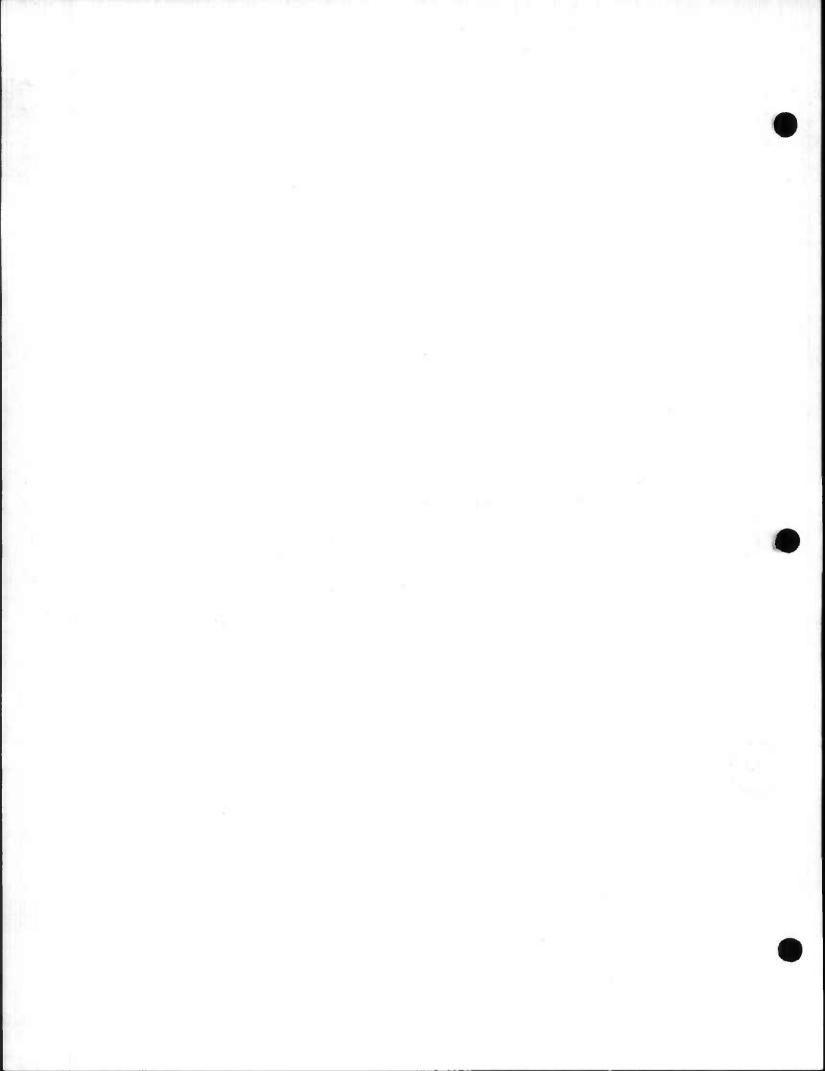
30. Neme end addrass of person who completed cause of daath (Itam 23a) (Type, Print)

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene

				Certificate of Deat	h i	Reg. No. 9 7	08008
	Dhyoia	ion	Decedent's Name (First, Middle, Last)	1 1	2. Date of Dec		3. Time of Death
	Physic /Medi		Betty	T. Edwards	3	13 199	
,	Exami		4a. Facility Name (If not institution, give street and number)	4b. City, 7	Town, or Location of Death	4c. County of De	eath
			2627 Rose wood Avenue	Da	Imore	NA	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 X F Usual Residence of Decedent	t birthday) If Under 1 Year If Under 1 Year Months Days Hours	er 24 Hrs. 8. Date of Birt (Month, Da	1, Year) 0-1936 9. B	Birthplace (State or Foreign Country)
	pue Mo			Town or Location			10d. Inside City Limits
	Mary	jo	Md NA Ba	Hmore			1 1 Yes 2 No
	the 128s	rec	10e. Street and Number	10f. Zip Code		10g. Citizen of What (Country?
	3a or	0	2627 Rosewood Avenue	2/2/5		//	CA
	death	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	Orlgin? (Specify Yes or No-	14. Race - Ar	merican Indian,
5-0020	72 hours after death with the Marylend natural', or items 23s or 28s-f show stool Examinet must be notified at	by	Armed Forces? 1 Never Married 2 Married I Yes, Give 3 Wildowed 4 Divorced Year or Dates:	If Yes, specify Cuban, Mexic		Black, Wi	Black
5-0	n 72 hours "natural",	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usuai Occupation (Give kind of work done during mo	act of warking	16b. Kind of Busines	ss/Industry
2121	permit. Pages 1 and 2 should be filed within 'Depertment of Health end Mental Hygjene. Important: If item 27 is marked other than "reny Injury or other traumatic event, I'm Marango.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Direct Care f	Assistant	State o	FMd
Pu	al Hy	Be (17. Father's Nama (First, Middle, Last)	18. Mot	ther's Name (First, Middle,	Meiden Sumeme)	
<u>X</u>	should be nd Mental marked o	10	William Davis	An.	nie Knigh	+	
Maryland	2 sho end is me			19b. Mailing Address (Street end Num	1	0	, Zip Code) 2/2/5
-	1 and 1 Health am 27 ther tr		Constince Ratliff Sister	4948 Edge,	nore Auen	4e 10a/ti	nive Md
ore	of H		20a. Method of Disposition 1 Burlal 2 Cremation 3 Removal from State	e of Disposition (Neme of etery, cremetory or other place)	Date	20c. Location - City	or Town, State
Ē	Pages nent of ant: If its ury or o		4 Donation 5 Other (Specify)	a Memoral Pa	AR 318-97	Kanda!	stown Md
Baltimore	permit. Pages 1 a Depertment of Her Important: If item any Injury or othe		21. Signature of Funeral Service Licensee	22. Name and Address of Fac	cility		7/2/1
00	89 = 58		1 Dlanders 1130 100) March 1-14	a) Haba	ch Anon	we by Ix will
			23a. Part1. Enter the disease, or complications that ceused the death.	Do not enter the mode of dying, such a	as cerdiac or respiratory ar	rest,	Approximate Interval Between
S.	Physician		shock, or heart failure. List only one cause on each line.				Onset and Death
и	/Medical		Immediate Causa (Final	ANDIO MICULA	100		Months
П	Examiner		rasulting in death)	s a consequence of):	14		1
ш		Je	Due to (or a		EMML SAN	ZUNC	hombe
	ires that the death certificate be executed signed by the attending physician and d be detached for use as the buriel-transit	Examiner	Sequentially list conditions Due to (or a	s a consequence of):	V 11 / 11,		, ,
o,	an ar		Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants Due to (or a		TES MELL	au	4 Ems
68760,	ite be nysici	Medical	Cause (Disease or injury that Initiated evants resulting in death) Last Due to (or a:	s a consequence of):			
	artifica ing ph e as ti	Med	resoluting in daturi) cast				
Box	th ce		d				1
	the att	sici	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying ceusa given in Par	rt I. 23b. Did t	obacco use contribu	ite to the cause of death?
P.0	es that the death cer igned by the attendin be detached for use	Physician/			10	res 2 No 3	Probably 4 Anknown
Ś	gned oo de	by F					/
ords,	is us					an autopsy 24th	b. Were autopsy findings available prior to
ě	2	piet					completion of ceuse of death?
岸	MI	Completed			101	es 20Avo	1 Yes 2 No
3	- 2	BeC	25. Was case referred to medical	26 Pie	ice of Death (Check only o		10100 2010
Division of VI	yalch is cur direct	ToB	examiner? 1 Yes 2 No Hospital: 1 inpatient 2 EF	Other	_	lence 6 Othar (Sp	nanifu)
0	Phy or this		27. Manner of Death 28a. Date of injury 20	Bb. Time of 28c. Injury at		ow injury occurred	овспу
o	oding th. : Afte	tio	1 ∰Natural 5 ☐ Panding (Month, Dey Year) 2 ☐ Accident investigation	Injury Work? M 1 Yes 2	□No		
/is	or Attending Physafter death. Director: After this of in by the funeral directed of the funeral direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home	a, farm, streat, factory, office		Street and Number or	Rural Route Number,
Ö	의 등 등 등	ert	4 Homicide determined building, etc. (Specify)		City or Tow	m, Stete)	
	Hospital 24 hours Funeral stely filled		29a. Certifiar Certifying Physician: To the best of my knowled	dga, daath occurred at the time, date a	and place, and due to the	causa(s) and mannar	as stated.
	Ho Ho	edical	(Check only one) 2 Medical Examiner: On the basis of axamination and manner stated.	and/or invastigation, in my opinion, de	aath occurred at tha tima,	data and place, and d	ue to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	×	29b. Signature and title of certifier	29c. License number	r	29d. Date signed (Mo	
	,		hei hum m	1)15	679	3-14	-92
	5		30. Nama and address of person who complated cause of death (Item 2)				
	')		EMIZIO RAMOS MIS	U. OF MA	40SPITAL 1	3 MTMON	€ 21201
	Sta	te	31 Data filed (Month Day Year) 32 Popietrade Signature			-	
	Registr		MAR 18 1997 June David	son-Aandelle			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month **Physician** Erwano Vincent 8:50 CM Mar /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard County General Hospital Columbia Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) **Funerai** Birthplace (State or Foreign Country) 1XM 2□ F Days Hours Yrs 133-16-8877 69 Director May 5, 1927 NY Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director Howard Woodbine 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or 1886 Woodbine Road 21797 USA death y Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1♥ Yes 2 □ No If Yes, Give Year or Dates: or items 11 Marital Status 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. efter 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced White natural', Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 18b. Kind of Business/Industry permit. Peges 1 end 2 should be filed within Department of Health end Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Outdoor Advertising Account Executive 12 None 17. Father's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Louis Ernano Yetta Kuhn 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Connie Migliaccio (Sister) 555 Mt. airy Rd. New Windsor, NY 20e. Method of Disposition 20b. Plece of Disposition (Name of cometery, cremetory or other plece) 20c. Location - City or Town, State Mar. 1 XBuriei 2 ☐ Cremation 3 XRemovel from State 4 ☐ Donetlon 5 ☐ Other (Specify) Gate of Heaven Cem. Vall Halla, NY 17, 1997 21. Signature of Funerel Service Licenses 22. Name end Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Rd. Columbia, MD 21045 23e. Pert1. Enter the disease, or confinications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximate Interval Betw Onset end Death **Physician** /Medical Immediate Ceuse (Finel Metastatic renal cell concer mos disease or condition resulting in death) Examiner Examiner certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequença of) Box 68760. Physician/Medical the Due to (or es e consequence of): 98 USB P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown Division of Vital Records, A 24b. Were autopsy findings available prior to completion of causa of death? Completed 24e. Wes an autopsy performed? The law req certificete 1 ☐ Yes 2 100 1 ☐ Yes 2 ☐ No director. Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 10 1 Yes 2 No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work?

funerai Certification:

I or Attending Physician: " effer death. Director: After this certifice the In by

To the Hospital within 24 hours a To the Funeral Completely filled Hospital

> State Registrar

Medical

29b. Signature and title of certifie

29c. License number D37012

1 Tyes 2 □ No

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and menner es steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, end due to the cause(s) end manner steted. 29d. Dete signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

A210 Bruce CONGER, MS

11055 Little Patagent Plany Columbia, Morary

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

MAR 18 1997

5 Pending investigetion

6 Could not be determined

1 Naturel

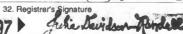
2 Accident

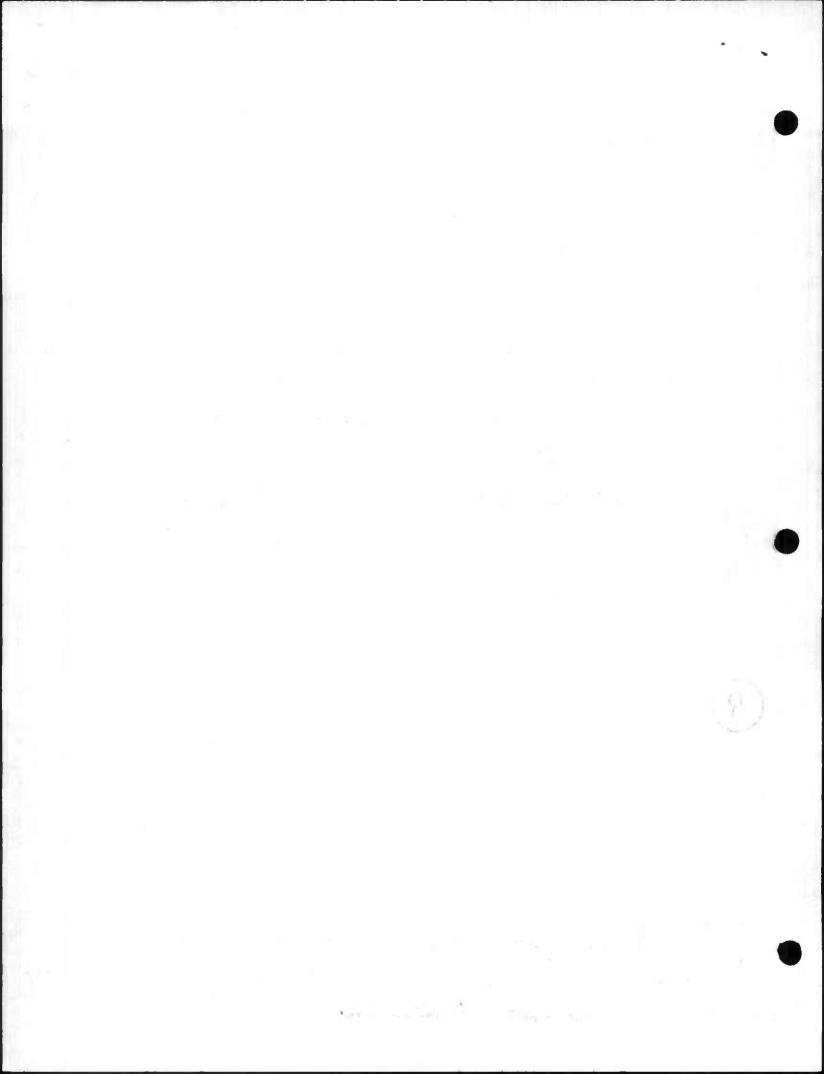
3 Sulcide

29a. Certifier

4 Homicide

31. Date filed (Month, Dey, Year)





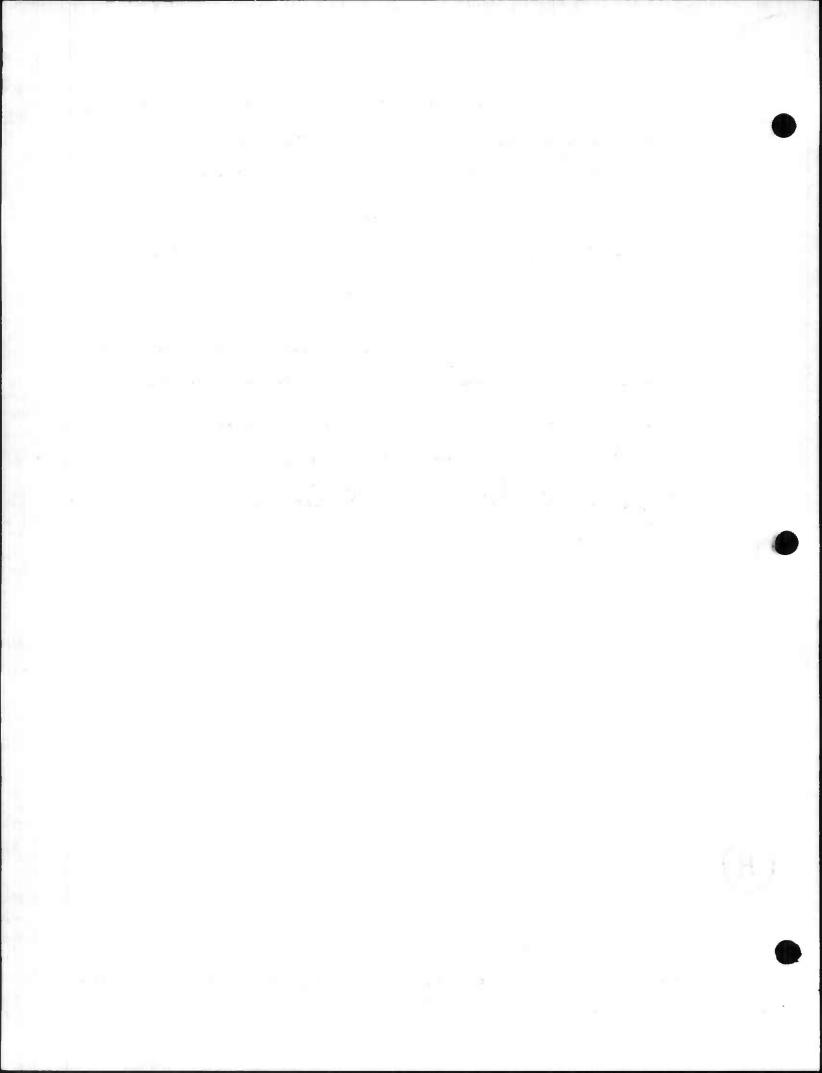
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** 1997 Katherine Thomsen Edmunds 2:30m 16, March /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Roland Park Place Baltimore H Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)

Jan. 31, 1917 If Under 1 Year Months | Days 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplace (State or Foreign Country).
7 Onio **Funeral** Days 1□ M 21 F 219-05-4001 80 Director Usual Residence of Decedent the Maryland 10e. State 10b. Count 10c. City. Town or Location "naturel", or flems 23s or 28s-f show 10d. Inside City Limits 1 Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t 830 W. 40th St. 21211 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. nt: If item 27 is marked other than "naturel", or ite 1 Never Merried 2 Married 1 ☐ Yes 2√7 No Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ White 3XIXVidowed 4 □ Divorced Year or Dates: Completed item 27 is marked other than "nature other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Il Hygiene. Elementary/Secondery (0-12) 1 2. College (1-4or 5+) Sales Representative Real Estate 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Thomsen Adelaid Porter Samuel T. . 2 19e. informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James R. Edmunds, IV/ Son 6211 Windy Ridge Rd., BAldwin, MD 21013 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town. Stete 1 Burial 2 remation 3 Removal from State 4 Donation 5 Other (Specify) Department Important: If any Injury or Druid Ridge Cemetery 3-20-97 Pikesville, MD 21. Signature of Funeral Servica Licensee 22. Name end Address of Fecility Henry W. Jenkins & Sons 4905 York Rd., Baltimore, MD 0 21212 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, show, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical 1 43 REST. ZATURY +arenze disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner 10 766 Charlie 035TRUCT.VE Phemodeny The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Last burial-tran Due to (or es e consequença of) P.O. Box 68760. 2 445 CAZENDONA OF LUNG Physician/Medical the Due to (or es e consequence of): for use as 142 RADIATION INDUCTS 下のいいい Phimidaey Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown CONFECT.SE MEAR FRIME Records, þ 99 page 2 should Completed 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Wes an eutopsy performed? CARDIOMOFORTAY certificate hes 1 ☐ Yes 2 No 1 Yes 2 No of Vital director. Physician: 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 1 Yes 2 No this 27. Menner of Death 1 Naturel 28e. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Do 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

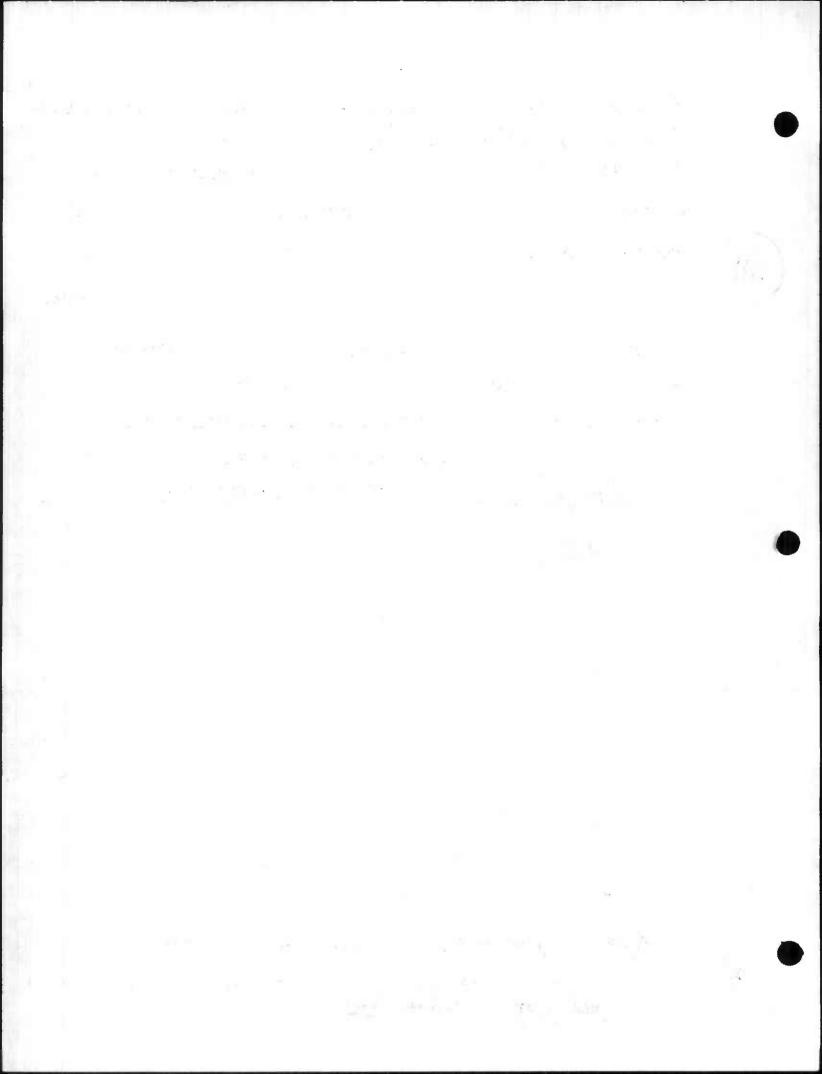
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical Hos 24 h (Check only one) within 2 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) J 12399 adone T m MARCH 17, 1997 J 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Charles O'Donovan, III, MD, 6565 Charles St., Towson, MD 21204 32. Registrat's Signeture Panda M. 31. Date filed (Month, Dey, Year) State MAR 18 1997 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certifica	ate of Death	,0	g. No. 97	08101
Physic	ian	Decedent's Neme (First, Middla, Last)		2. Date of Deeth Month	Dey Yea	3. Time of Death
/Medi		CLARENCE O FRANKI		MARCH	13 199	7 11:43 PM
Exami	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Lo	cation of Death	4c. County of De	
Formul	-	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) J. Und	der 1 Year If Under 24 Hrs.	8. Date of Birth	n/	
Funeral Director		557 26 4039 XXM 2 F 82 Yrs. Month	is Days Hours Min.	8. Date of Birth (Month, Day, March 17	,1914 T	irthplace (Stata or Foraign Country) 'exas
Maryland a-f show iffed at	tor	10a. State 10b. County 10c. City, Town or Location 10a. State	Baltimore	- 1		10d. Inside City Limits 1 Yes 2 No
	al Director	10e. Street end Number 1221 Camberwell Rd.	Zip Code 21228	10	g. Citizen of What C United S	
NA PARTIES	by Funeral	3 ☐ Widowed 4 ☒ Divorced If Yes, Give 1 ☐ Yes	cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto 2X) No Specify:	ecity Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	nericen Indian, lite, etc. White
5-0 72 ho	ted	15. Decedent's Education 16a. Decedent's Us (Specify only highest grade complated) (Give kind of v	sual Occupation	1	6b. Kind of Busines	s/Industry
Maryland 21215-00; d2 should be filed within 72 hours in and Mental Hygiens. The marked other than "natural traumatic event, the Medical Exp.	Completed	Elementery/Secondary (0-12) College (1-4or 5+)	,	ng	Railroa	d
Page 4	ပ္ပ	12 Yard M				.u
BUG STEEL	Be	17. Fether's Name (First, Middle, Last) Babe Franklin	18. Mother's Name	<i>(First, Middla, M</i> Robison	aidan Sumeme)	
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Ma d2 g d2 g d2 g d2 g d2 g d2 g		· ·	oss (Streat and Number or Rural . 35th St., Co.			
re, N s 1 and f Health ltem 27 other t		20e. Method of Disposition 20b. Placa of Disposition (N	lama of		Oc. Location - City of	
0 80=5		1 ☐ Burial 2 (XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount		17/97	Baltimor	
altim nit. Pa artmen ortant: injury			and Address of Facility	1757	Datcinor	e, MD
B Ped Para		tished tolumann 8717	Stephen D. Loh Green Pastures	s Dr., B	altimore,	MD 21286
		23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on each line.	ode of dying, such as cerdiec o	r respiratory arres	st,	Approximete Interval Between
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting In death) a. Venkricular tachy				Onset and Death
	Jer	Due to (or as a consequence of	f):			
58760, icete be executed physician and s the bunal-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or es a consequenca of injury that initieted events Due to (or as a consequence of	n):			
= 00	-	Cause (Disease or injury that initieled events resulting in deeth) Last Due to (or as a consequence of d.):			
Box eath cert ettendin	clar					
ds, P.O. Box ires that the death cent signed by the ettendin d be detached for use	by Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying				te to the cause of death?
that	Y P	Chronic Obstructive Polmonary Disease	-	1 Yes	2 No 3	Probably 4 Unknown
requ houl	Completed b	Chronic Debility		24e. Was an perform	autopsy 24b	. Were eutopsy findings eveileble prior to completion of ceuse of death?
	EO	Fecal moaction/constitution requiring hospital	admission	t₩ZÎ Yes	2 No	1 □ Yes 20 No
	Bec	25. Was case referred to medical	26. Place of Deeth			12.100 22410
of Vital Physician: T this certificat	2	exeminer? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 D	Other		ce 6 □Other (Sp	ecify)
O Ph Ter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) 28b. Time of Injury		28d. Describe how		
Division or Attending after death. Director: After In by the fune	Certification:	2 Accident investigation 3 Sulcide 6 Could not be determined edge and sulcide successful and suc	1 ☐ Yes 2 ☐ No	28f. Location (Stre	et and Number or I	Rural Route Number,
S aft or of in or of	Cer	4 Homicide building, etc. (Specify)		City or Town,	olele)	
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred to the best of examination end/or investigation and manner stated.	d at the time, dete and place, a on, in my opinion, death occurre	and due to the cau ad at the time, dat	se(s) and menner of e end piace, end du	es steted. se to the cause(s)
To the Comp	Σ		9c. License number	290	d. Dete signed (Mor	oth, Day, Year)
1.1		Spence 3 NalingMo	P08677	3	3/14/97	
a(X)	-	30. Name end address of person who completed cause of death (Item 23a) (Type, Print)	100011		, , , ,	
(1)		SPENCER J. MARHOWITZ, MD 22 South 6	reene St., Medico	a Resident	s office Bal	10212 OA, Somit
Sta Registr		31. Date filed (Month, Day, Year) MAR 18 1997 Signature MAR 18 1997	Lies .			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth March 16, 1997 Year Caroline J. Famback 11:30 A.M. 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 12624 Milburn Lane Bowie Prince George 5. Social Security Number If Under 1 Yeer if Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) 10M XOF Deys Hours Min Yrs. 219-18-3500 June 6, 1903 Virginia Usual Residence of Decedent 10e Stete 10h County 10c. City. Town or Location 10d. Inside City Limita Anne Arundel Maryland Pasadena 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1225 Rockhill Road 21122 U.S.A. 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 11. Meritel Stetus Was Decedent of Hispenic Origin? (Specify Yea or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American indian, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No Specify: White 3 Ø Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Secretary Clothing Company 11 N/A 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Morgan Jones Viola Ticer 19e. Intorment's Neme/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Bruce M. Conley (grandson) 12624 Milburn Lane Bowie, Maryland 20e. Method of Disposition
1 □ Burial 2 □ Cremetion 3 □ Removel from Stele 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Stete 4 ☐ Donetlon _5 ☐ Other (Specify) The Green Mount Cemetery 3/18/97 | Baltimore, Maryland 21. Signature of Funeral Segree Lies Mc Cully Funeral Home of Pasadena 3204 Mountain Road Pasadena, Maryland of plications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, one cause on each line. 21122 Approximate Interval Between Onset end Deeth PANCREATIC CARCINOMA Immediete Ceuse (Finel MONTHS disease or condition resulting in deeth) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last Due to (or es e consequence ot): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably ↓ Unknown 1 ☐ Yss 2 ☐ No 24b. Were autopsy tindings available prior to 24a. Wes en eutopay performed? completion of cause of death? 1 □ Yes 2 No 2X No 1 Yes 25. Wes case referred to medical examiner? 28. Piace of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA

attending physician and for use as the burlel-transit P.O. Box 68760 signed by I Records, ete hes been sig page 2 should b certificete Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p.

Examiner Physician/Medical à Completed Be Certification: To

Physician

/Medical

Examiner

Funeral

Director

28a-t show

Baltimore, Maryland 21215-0020

52 should be fill h and Mental H I is marked off

permit. Pages 1 and 2 should be Department of Health and Mental important: if them 27 is marked any injury or

Physician

/Medical

Examiner

Director

Completed

Be

27, Magner of Deeth

1 Neturel 5 Pending Investigetion 2 Accident 6 Could not be determined 3 Sulcide 4 Homicide

28e. Dete of Injury (Month, Dey Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

28b. Time of

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred 28t. Location (Street end Number or Rural Route Number, City or Town, Stete)

🖄 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner as steted. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted.

29b. Signeture and title of certifier

29a, Certifier

29c. License number

29d. Dete signed (Month, Day, Year)

State Registrar

edical

31. Dete tiled (Month, Dey, Year) MAR 1 8 1997

8926 WOODYARD ROAD SUITE 201 GUPTAMD. 32. Registrer's Signeture lia Davidson

28e. Plece of Injury - At home, ferm, street, tactory, office building, etc. (Specify)

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State of Maryland / Department of Health and Mental Hygiene

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Funera Directo			213-76-5461	Sex 7. A	ge (In yrs. las 34	st birthdey, Yrs.	If Und Month	er 1 Year s Days	If Under Hours	Min.	B. Dete of Bi (Month, Da 12-29	irth ay, Year) -1962	9.	. Birthplece Country)	(Steta or Foraig
show ed at		h	Usuel Residence of Decedent 10a. Stete 10b. County		10c. City,	Town or L	ocation							10d.	Insida City Limits
the Man 28a-f et notified	ctor	5	MD Har	ford				На	vre c	de Gra	се				1⊠ Yas 2□No
vith th	Director		10e. Street and Number				10f. Z	ip Code				10g. Citiz	en of Whe	et Country?	
eath w	Funeral	5	129 Weber	Street 12. Was Deceden	t Ever in U.S.	12	Was Dag		21078	rigin? (Speci	ifu Vac or N	0. 1	I4. Race -	USA American I	ndien
filled within 72 hours efter death with the Maryland Hygiene than "natural", or items 23a or 28a-f show int, in Modical Examiner must be notified at	by Fun		1 Never Married 2 Merried 3 Widowed 4 ⊠ Divorced	Armed Forces 1 Yes 2 If Yes, Give Yaar or Dates:	? No				an, Mexice Specify	rigin? (Speci on, Puerto Ri	icen, atc.)			White, etc.	ite
72 ho			15. Decedent's Ed (Specify only highest gra	ducation		16a. Dece	dent's Us	uei Occuj	oation	st of working	,	16b. Kir	nd of Busin		
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12 should be h end Mentel 7 Is merked o	ို	2	Melvin G. 19a. Informent's Name/Reletionship (19b. Maili	na Addre	ss (Street	end Numb	Janet	N. F			ate Zin Co	del
			Mr. Melvin G. Fl							Aber			210		36)
N H O		2	20e. Method of Disposition 1 Buriai 2 □ Cremetion 3 □		cern	ce of Disponetery, cre	osition (N metory or	eme of other ple	се)		Dete		cation - Cit		Stata
permit. Pages Department of Important: If It any Injury or		-	4 ☐ Donetion 5 ☐ Other (Specification of Funeral Service Licer		Ang	gel H			ery iss of Facil		4/97	Hav	re d	le Gr	ace, MD
permit. Departments Imports any Inje			23a. Pert1. Enter the disease, or com	?. S.	AL		Mitc Hav	hell- re d	Smith e Gra	n Fun	ID 21	1078-		١.	
Physiciar /Medica Examine	ı		Immediate Ceuse (Finei disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury	CORONARY BACTERIA b.	Due to (or a	s e conse C VALV	ULITI	r): S							set and Deeth
the death certificete be executed y the attending physician end sched for use es the bunial-transit	Physician/Medical I		Cause (Disease or injury that initiated events resulting in deeth) Last	d	Due to (or es	s e consec	quence of):							
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al or Attending s after death. II Director: After ed in by the lune	Certification:		3 Suicide 6 Could not be determined	286. Place of in	ijury - At homo tc. (Specify)	e, farm, st	reet, facto	ory, office		28	f. Location (City or To	(Straet end wn, State)	d Number o	or Rurel Ro	oute Number,
To the Hospital or Att within 24 hours aftar d To the Funeral Direct completaly filled in by	edicai (29a. Certifier 1□ Cartifying Ph (Check only one) 1□ Cartifying Ph	ysician: To the best ainer: On the besis of and menner si	of exeminetion	edge, deet n and/or in	h occurre vestigetio	d et the ti	me, dete er epinion, dea	nd plece, enath occurred	d due to the et the time,	ceuse(s) date end	end menne plece, and	er es stete I due to the	d. ceuse(s)
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			Dennis (C)	hute no				0.	C.M.	E		MAR	CH 2	2, 19	97
		3	Dennis J. C	hute w	deeth (Item 23	^{3е) (Туре,} 1 Ре	Print)	Stre	et,	Balti	imore	, Ma	ryla	and 2	21201
Si Regis	tate	3	31. Dete fijed (Month, Dey, Year)	32. Regist	rer's Signatur		Į.								

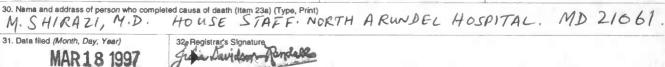
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month Yaa **Physician** 11-10PM 1997 MARCH /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner th Hrunde AnneArunde Hospita Glen Burnie If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 212-36-6791 Yrs. 80 1916 Director Maryland Usual Rasidance of Dacedant Pages 1 and 2 should be filed within 72 hours after death with the Man/lend enti of Heelth and Mental Hygiene. Intel if then 221 is marked other than "natural", or itema 23a or 28=4 show mits if item 27 is marked other than "natural", or him a 23a or 28=4 show my or other traumatic event, its Medical Essaniver mast by notified a! 10a. Stata 10b County 10c. City. Town or Location 10d. Insida City Limits MD Anne Arundel Linthicum 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 6210 Medora Road 21090 USA Funeral 12. Wes Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ②No If Yes, Giva Yaar or Datas: 11 Meritei Status Was Decedant of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Biack, Whita, atc. 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grada completed) Eiamentary/Secondary (0-12) Coilega (1-4or 5+) Ordained Clergy Lutheran Church 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Paul I. Folkemer Laura Becker 2 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) A. Margaret Folkemer/wife 6210 Medora Rd. Linthicum, MD 21090 20b. Placa of Disposition (Nama of cemetary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 M Cramation 3 ☐ Ramoval from Stata permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Othar (Specify) Metro Crematory, Inc. 3/17/97 Baltimore, MD 22 Nama end Addrass of Facility Cremation Society of Maryland, Inc. 21. Signeture of Funaral Sarvice Licensee George E. MacNabb 299 Frederick Rd. Baltimore, MD 21228 23e. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximeta Intarvai Batween Onset and Death **Physician** ACCID ENT tmmediata Causa (Finai diseasa or condition rasulting in death) /Medical CEREBROVASCULAR 4 DA41 **Examiner** Dua to (or as a consequence of) Physician/Medical Examiner physician and the buriel-transit certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated avants resulting In death) Last Dua to (or as a consequanca of): Box 68760. Dua to (or es e consequença of) 88 esn Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the causs of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records. þ 24b. Wara autopsy findings svallable prior to complation of cause of death? Completed 24a. Was an autopsy peed 1□ Yes 2 No 1 Yes 2 No or Attending Physician: Be 25. Was casa rafarred to medical 28. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitai: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No 10 After this 28c. injury at Work? 27. Mangar of Death 28b. Tima of Certification: 28d. Describe how injury occurred 1 Natural 5 Panding invastigation s efter death. 1 ☐ Yas 2 ☐ No 2 ☐ Accident 8 Could not be datamined 3 ☐ Suicida 28a. Placa of injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicida Hospital 24 hours 29a. Cartifian 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. Medical (Check only one)

State Registrar

31. Data filed (Month, Day; Year)

29b. Signatura and title of cartifia

MAR 18 1997



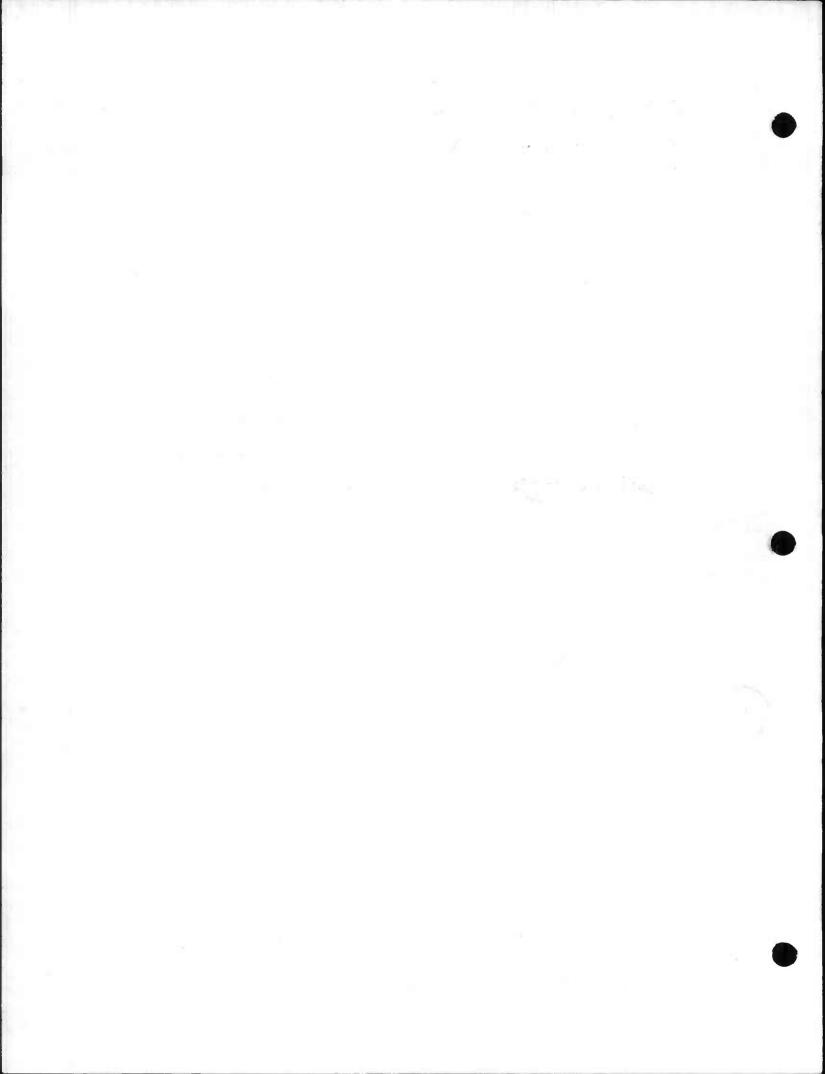
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State of Maryland / Department of Health and Mental Hygiene

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			Holy Cross Ho	spital				Silver S	oring	Mont	gomery	
	Funeral Director		5. Social Sacurity Number 578-05-8544	6. Sax 7.	Aga (In yrs. 88	iast birthday) Yrs.	If Under 1 Year Months Days	if Undar 24 Hrs.	8. Data of Bir (Month, Da		9. Birthpiaca	(Stata or Foraign ylvania
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V	To t To tt	M	29b. Signature and titla of certifi	ar			29c. Licans	28656		29d. Data signed	Month, Day,	
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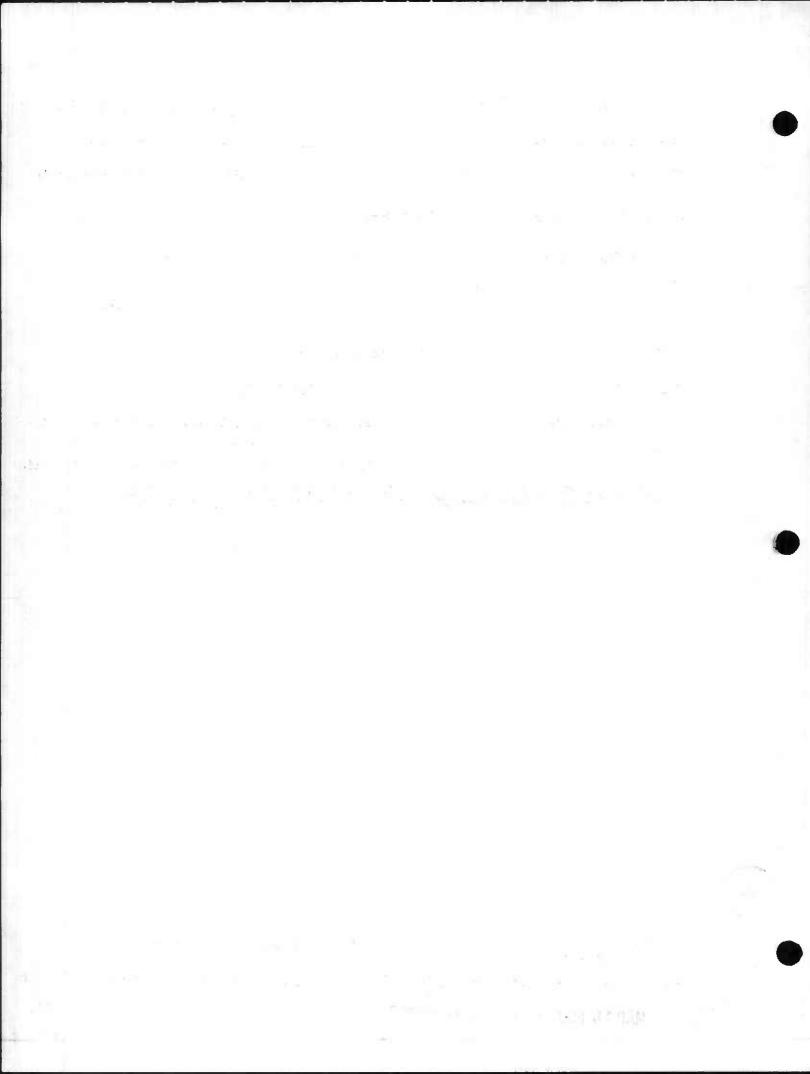
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Registrar

31. Data filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene

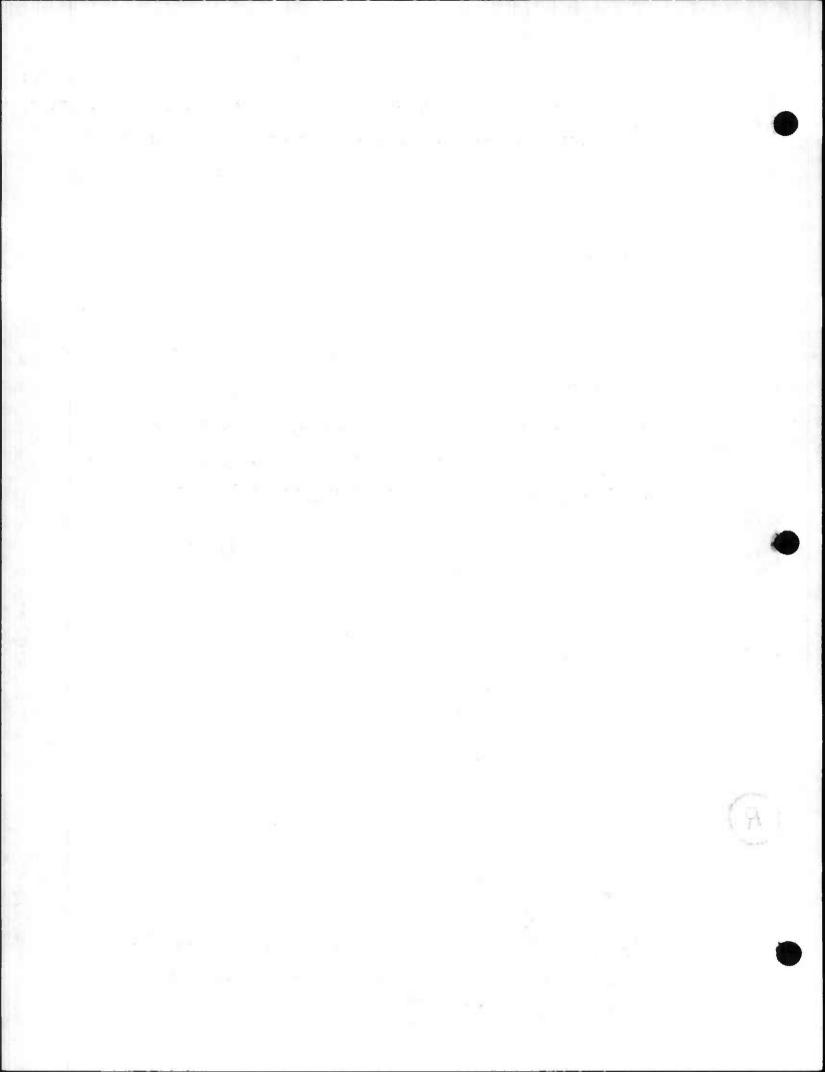
Certificate of Death 1. Decedent's Name (First, Middla Last) 2. Dete of Death 3. Time of Deeth Day Month Year **Physician** William Alfred FRANZ 6:30 p.m. March 12, 1997 /Medical 4e. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** Franklin Square Hospital Center Rosedale Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ♥ M 2 □ F Months Yrs Director APRIL 29,1917 79 217-01-3137 BALTIMORE CITY, MD. Usual Residence of Decedent the Meryland 10a Stete 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2x No Directo MARYLAND BALTIMORE BALTIMORE COUNTY 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 4505 PULLERTON AVENUE 21236 U.S.A. death 12. Was Decedent Ever in U,S. Armed Forcas? 1 XX vas 2 □ No If Yes, Give Year or Dates: WW ☐ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American indian, Black, White, etc. ages 1 and 2 should be filed within 72 hours after ont of Health end Mental Hygiene.
If fem 27 is marked other than "natural", or filer or other traumatic evant. Its Med. 1 ☐ Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WW II WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) 12 PRINTER DAILY RECORD CO. N/A 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Meiden Sumeme) Be JOSEPH FRANZ HELEN HENEKE ပ 19a. informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 4505 FULLERTON AVENUE BALTIMORE, MARYLAND 21236 PUTH G. FRANZ (WIFE) 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stata Peges nent of F 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from Stata permit. Pege Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) PARKWOOD CEMETERY MARCH 17, 1997 BALTIMORE, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facilit LASSAHN FUNERAL HOME, INC. 23a. Part1. Enter the disease or complications that caused the death. Do not enter tha moda of dying, such es cardiac or respiratory arrast, shock, or heer feilure. List only one ceuse on each line. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236-4625 Approximate Interval Between Onset end Deeth Physician /Medical Immediate Cause (Final 2 Hours disease or condition resulting in death) e Massive Food Aspiration **Examiner** Due to (or as e consequence of) Examiner Dysphagia the bunel-transit b. end Sequentielly list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that Initieled events rasulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Cerebrovascular Ischemia and Stroke 2 Physician/Medical Due to (or as a consequence of): es e Atherosclerosis Po Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? ed by 1 Yes 2 No 3 Probably 4 Unknown Coronary Artery Disease þ 24e. Wes an autopsy performed? 24b. Were autopsy findings evailable prior to Completed Ischemic Cardiomyopathy completion of cause of deeth? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Atrial Fibrillation Division of Vital Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 【X ER/Outpatient 3 ☐ DOA 1 Yes 2 No 10 컱 27. Manner of Deeth 28a. Date of injury (Month, Day Year) 28c. injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After 1 X Neturei 2 ☐ Accident 5 Pending investigation 1 Yes 2 No In by the 3 Suicida 6 Could not ba determined 28e. Place of Injury - At homa, farm, straet, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 D Homicida edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data end piace, and due to the ceuse(s) and menner es stated.

| Medical Examiger:/*Dn the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the course of the time. 29a. Certifier iper. On the basis of exeminetion end/or investigetion, in my opinion, death occurred at the time, date and piece, and due to the cause(s) 29b. Signature and titla of certifie 29c. Licanse number 29d. Date signed (Month, Dey, Year) D 42083 March 12, 1997 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Gunta Wheeler 9000 Franklin Square Drive Baltimore, Maryland 21237 31. Date filed (Month, Day, Yeer) gistrar & Signature State Registrar MAR 18 1997

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State of Maryland / Department of Health and Mental Hygiene

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re cer this confliction has been signed by the attending to the chart is conflicted for use	Certification: To Be	Sequentially list of any, leading to cause. Enter Unc Cause (Disease of that Inflicted aven rasulting in death) Part II. Other sign Pi New L 25. Was casa rafa axaminer? 1	conditions, immediate derlying or trijury its in the conditions of	b. A &	Due to (c) Due to	or es a consequence de la consequence del consequence de la consequence de la consequence de la consequence de la consequence de la consequence de la consequence de la consequence de la consequence del consequence de la consequence de la consequence de la consequence de la consequence de la consequence de la consequence de la consequence de la consequence de la consequence de la conseque	uance of): uance	26. Pteca of Other: 4 Nursinjury at Work? 1 Yas 2 Notice e tima, deta and in my opinion, daath tense number	28d. 28f.	24a. Was ar perform 1 Ya 1 Ya 1 Reside Describe ho Location (Str. City or Town dua to the cat the time, de	n autopsy ned? s 2 No a) nca 6 Oth w injury occur raat and Numb, , Stata) usa(s) and muste and ptaca,	3 Protein 24b. Was averaged of the second of	are autopsy findings allable prior to mpletion of cause death? Yes 2 No // Route Number, atad. the cause(s)
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ver this conficults has been aloned by the attending to the chart pape 2 should be detached for use	Medical Certification: To Be	Sequentially list of any, leading to causa. Enter Unc Causa. Enter Unc Causa (beause of that initiated aven resulting in death of the causal o	arred to medicat No ath Certifying Pr 2 Medical Exact ditte of certifier Trass of person who	d. c. Multiple of the contributing to describe the contributing to describe the contributing to describe the contributing to describe the contribution of the contrib	Due to (c) Due to	or es a consequence de la consequence del consequence de la consequence de la consequence de la consequence de la consequence de la consequence de la consequence de la consequence de la consequence del consequence de la consequence de la consequence de la consequence de la consequence de la consequence de la consequence de la consequence de la consequence de la consequence de la conseque	uance of): uance	26. Pteca o Other: 4 Nurs tnjury at Work? 1 Yas 2 No ice	28d. 28f.	24a. Was ar perform 1 Ya 1 Ya 1 Reside Describe ho Location (Str. City or Town dua to the cat the time, de	n autopsy ned? s 2 No a) nca 6 Oth w injury occur raat and Numb, , Stata) usa(s) and muste and ptaca,	3 Protein 24b. Was averaged of the second of	are autopsy findings allable prior to mpletion of cause death? Yes 2 No // Route Number, atad. the cause(s)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Item20a 3-18-97 FilmG745 W.H.Per State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Yeer 1:52 PM Graves Teorgia Tarck. 1997 /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner South NA Baltimore and treet If Under 1 Year if Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 6. Sex Birthpiece (State or Foreign Country) **Funeral** 1□ M 2 F Deys Hours 212-40-3849 Yrs. Director Usuei Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or itsms 23a or 28a-f shorthe Medical Examiner must be notified at Baltimore NA 1 Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 3011 South land U.S.A Street 21225 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D/No If Yes, Give Yeer or Detes: 11. Marital Stetus Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify Completed by Black 3 Widowed 4 □ Divorced Decedent's Usual Occupation
 (Give kind of work done during most of working
 life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondary (0-12) Coilege (1-4or 5+) 12 th grade Fether's Neme (First, Middle, Last) traumatic event, permit. Pages 1 and 2 should be file Department of Health end Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surneme) Be 0 ones Mala 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Hndrian aughter 20b. Placa of Disposition (Name of cemetery, cremetory or other place) lace N.J. Edison

Physician /Medical **Examiner**

Baltimore, Maryland

Physician/Medical þ

Examiner The law requires that the death certificate be executed the buriel-tran USB 88 signed by Completed certificate has Physician: Certification: To Be this

of Vital Records, P.O. Box 68760,

immediate Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest

20a. Method of Disposition

21. Signeture of Funerel Service Licensee

4 Donetion

Cremetion 3 ☐ Removel from State 5 ☐ Other (Specify)

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line.

Due to (or es a consequence of)

Pert il. Offer eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i.

Remia

23b. Did tobecco use contribute to the cause of death? 2□ No 3 Probably 4 Unknown

20c. Location - City or Town, Stete

24e. Wes en eutopsy

24b. Were eutopsy findings eveileble prior to completion of cause of deeth?

Approximate intervel Between Onset and Deeth

1□ Yes 2□No

1 ☐ Yes 2 ☐ No

28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify)

Date

28c. injury et Work? 28b. Time of 28d. Describe how injury occurred injury 1 Yes

Crematury

22. Name and Address of Facility

28e. Plece of injury - At home, farm, street, fectory, offica building, etc. (Specify)

1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date end pleca, and due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end pleca, end due to the ceuse(s) and menner steted. (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year)

29b. Signature end title of cartifier

5 Pending investigation

6 Could not be determined

McCause of deeth (Item 23e) (Type, Print) ONALD

31. Dete file MAR 18 1997

25. Wes case referred to medical

exeminer?

27. Manner of Deeth

1 Naturei 2 ☐ Accident

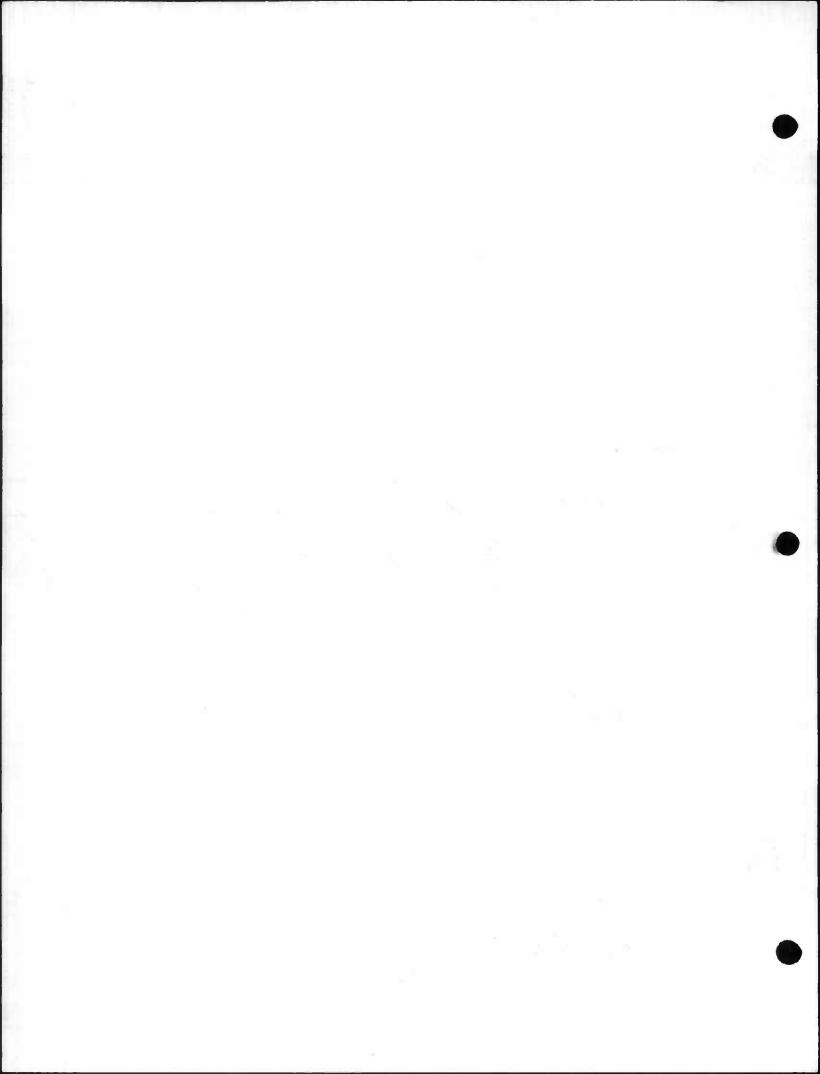
3 Sulcide

4 Homicide

To the Hospi within 24 hour To the Funera completely Illa

Medicai

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Eileen F. Goriup MATCH 14 1997 4e. Fecility Name (If not institution, give straet end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Lorien Nursing Home Howard County Columbia 5. Social Security Number If Undar 1 Yaar | If Under 24 Hrs. 8. Data of Birth Month, Day, ADIII 23, 7. Aga (In yrs. iest birthday) 9. Birthpieca (Steta or Foreign Deys Hours 1 M 25€ 92 NEW York 215-46-394 Yrs. Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Howard County Columbia 1 ☐ Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6334 Cedar Lane 21044 USA

1 Yas 2 No Specify:

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working iffe. DO NOT use retired)

22. Name end Addrass of Facility

Peropheral VAJaulas

28c. Injury et Work?

Certifying Phyelcian. To the best of my knowledge, deeth occurred et the time, dete and place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, date end plece, end due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

homemaker

20b. Plece of Disposition (Neme of cematery, cremetory or other plece)

M00535

Pen1. Enter the disaase, or complications thet causad tha death. Do not anter the mode of dying, such as cerdiac or respiretory errast, shock, or heart feilure. List only one cause on each line.

Due to (or es e consequence of):

Due to (or as a consequence of):

Athero Schooses Dua to (or as e consequance of):

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Piece of Injury - At home, farm, straet, factory, office building, etc. (Specify)

28b. Time of

Arlington National Cemetery

Was Decedent of Hispenic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - Amaricen Indien, Black, White, etc.

Specify: white

16b. Kind of Business/Industry

20c. Location - City or Town, Stata

Approximete Interval Between Onset and Deeth

Arlington, VA

desease

24a. Wes en eutopsy performed?

1 Yes

28d. Describe how Injury occurred

Other: Nursing Home 5 Residence 8 Other (Specify)

26. Plece of Deeth (Check only one)

200 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Dete signad (Month, Day, Year) Mrsc 17, 1997

Columbia me 21044

23b. Did tobacco usa contributa to the causa of death?

1 Yes 2 No 3 Probably 4 Unknown

24b. Were eutopsy findings evelleble prior to completion of cause of deeth?

1 ☐ Yes 2 No

own home

18. Mother's Neme (First, Middla, Meidan Surnama)

Katherine E. Dwyer

Dete

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

16915 North Golden Dr., Colbert, WA 99005

Ellicott City, Maryland 21043

Slack Funeral Home, P.A.

Physician /Medical Examiner

Baltimore, Maryland 21215-002

Pages 1 and 2 should be nent of Health and Mental

10 nt of Health a :: If Item 27 is r or other tra

Physician

/Medicai

Examiner

10a State

11. Maritel Status

1 Never Merried 2 □ Married

15. Decedent's Education

(Specify only highest grede completed)

Ms. Carrie Goriup/granddaughter

Burial 2 Cremetion 3 Remove from State

3 Widowed 4 □ Divorced

Eiemantery/Secondary (0-12)

20e. Method of Disposition

Immediate Cause (Finel disaese or condition resulting in death)

Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest

25. Wes case referred to medical

1 Yes 3 No

27. Manner of Deeth

2 Accident

3 ☐ Suicide

29e. Certifier (Check only one)

4 Homicide

17. Fether's Name (First, Middle, Last)

19e. Informent's Name/Reletionship (Type, Print)

4 ☐ Donetion 5 ☐ Other (Spacify)

21. Signature of Funerel Sarvice Licensea

Director

Funeral

Be Completed by

P

Physician/Medical Examiner

þ

Completed

Be

P

Certification:

Medical

Funeral

Director

The law requires that the death certificete be executed the burial-trer P.O. Box 68760. signed by I Division of Vital Records, peeu this certificate has Attending Physician: After death. after death Director: 3

> 0 State

To the Hospital of within 24 hours at To the Funeral D completely filled in

MAR 1 8 1997

29b. Signature and little of ce

Julia Davidson

12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes ৣ YCNo ff Yes, Give Year or Dates:

College (1-4or 5+)

James Francis Shortell

Sepsis

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28e. Dete of Injury (Month, Day Year)

and mennar stated.

Hospital:

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

5 Pending investigation

6 Could not be determined

31. Dete filed (Morlin, Dey, Year)

32. Registrer 11055 Little Parusel My 32. Registrer's Signeture

Registrar DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death March 17, Del 1997 Yeer **Physician** Richard Shaw Garrabrant 7:30p /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 3654 MacAlpine Road Ellicott City Howard County If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Months Deys Hours Min. September 27,1933 5. Sociel Security Number 9. Birthplece (State or Foreign Country) New Jersey 7. Age (In yrs. lest birthday) **Funeral** 1**⊘**M 2□ F Months 137-28-2518 63 Yrs. Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Howard County Ellicott City 1 ☐ Yes 21 No Director 10f. Zip Code 21042 10e. Street end Number 10g. Citizen of Whet Country? 3654 MacAlpine Road USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 11 Maritel Stetus 1 Never Married 25 Married SpecifyWhite 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) marine specialist insurance co. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be John William Garrabrant Edith Shaw 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) vepartment of Health as important: if frem 27 is a sary injury or Ms. Barbara Garrabrant/spouse 3654 MacAlpine Road, Ellicott City, MD 21042 20a. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2XXCremetion 3 ☐ Removel from State Baltimore Washington Crematory 3-18-97 Laurel, Maryland 4 □ Denetion 5 □ Other (Specify) al Funeral/Service Licensee 22. Name end Address of Fecility Slack Funeral Home, P.A. M00535 Ellicott City, Maryland 21043 o complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, st only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Im nedlate Ceuse (Finel disease or condition resulting in death) Metastatic 24rs **Examiner** Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 → thknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of death? Be Completed 24e. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No Certification: To 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Dete signed (Month, Dey, Year)

March 18, 1997

Records, P.O. Box 68760.

cate hes been sig Division of Vital

To the Mospital or Attending Physician: The law requires that the death certificate be executed within 24 hours eight death.

To the Funeral Director: After this certificate hes been signed by the ettending physician and completely filled in by the funeral director, page 2 should be deteched for use as the bunkel trensit

28a-f show

herrs 23a or

is marked

Saltimore, Maryland 21215-0020

0

edical

State Registrar

JAMES A. DAY, JR 31. Dete filed (Month, Dev. Year) MAR 1 8 1997

29b. Signature and title of certifi-

3 ☐ Suicide

29e. Certifier one)

4 Homicide



30. Name end editions of person who completed cause of deeth (Item 23e) (Type, Print)

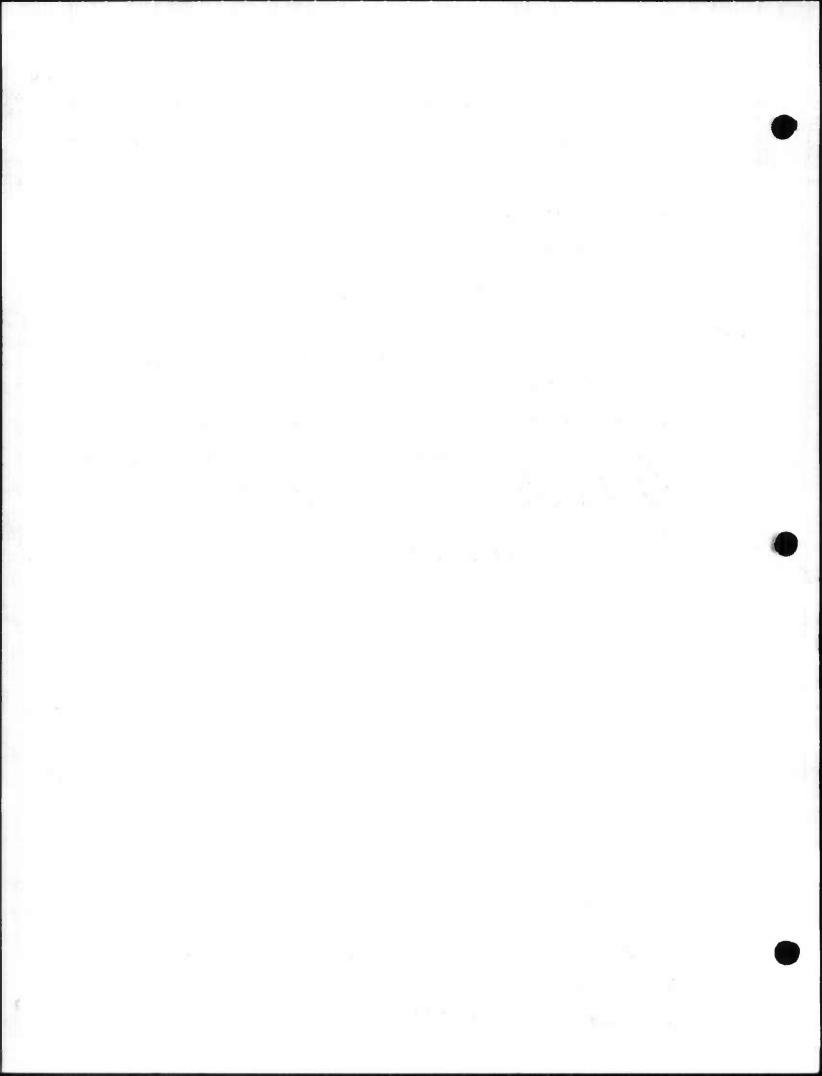
28e. Pleca of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

Contifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated.

In dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

D-42187

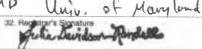


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle Last) 2. Dete of Death 3. Time of Deeth **Physician** Month Scott Graves 3 /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore University Baltimore Mary and If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. 1 1 Month Day (Year) 5. Sociel Sacurity Number 7. Age (In yrs. last birthday) **Funerai** 9. Birthpleca (State or Foreign Continuous yland 1 ₹M 2 □ F 218-62-2170 41 Yrs. Director Usual Residence of Decadent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 lis marked other than "nature." 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Arbutus Funeral Director 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5235 Pasteur Road 21227 U.S.A. 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Datas; 11. Marital Stetus Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 ☐ No Specify White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Social Security Elamentery/Secondary (0-12) College (1-4or 5+) Audit Specialist Credit Union 17. Fether's Neme (First, Middle, Last) 18. Mother's Nema (First, Middle, Malden Surnema) Be Norma Gulledge 10 John Graves 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5235 Pasteur Road, Arbutus, MD 21227 Pamela F. Graves (Wife) 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cramatory or other place) 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Remove from Stete 3/18/1997 Maryland 4 ☐ Donelion 5 ☐ Other (Specify) Dulaney Valley 21. Signetura of Funerei Sarvice Licansea 22. Nema end Address of Fecility Witzke Funeral Home of Catonsville 1630 Edmondson Ave, Catonsville, MD 21228 23e. Pert1. Enter the disease, or combilidations that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart fellure. List only one cause on each line. **Physician** /Medical Immediete Cause (Finel Dulmonary Embolus disaese or condition resulting in deeth) Examiner Due to (or es e consequenca of) Physician/Medical Examiner lines that the death certificate be executed bunel-transit Sequentielly list conditions, if any, leeding to immediate cause. Entar Underlying Couse (Diseese or Injury that Initiated events resulting In death) Last Due to (or es e consequença of): Viral Records, P.O. Box 68760, attending physician for use as the buse the Dua to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco uas contribute to the cause of death? gned by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown by 8 Completed 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? 1□ Yes 2M No 1 ☐ Yes 2 No Be 25. Wes case referred to medical exeminer? 28. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Attending Phys Division of 27. Menner of Death 1 Neturel 28e. Dete of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 Yas 2 No ector: / 2 Accidant 6 Could not be determined 3 Sulcide 28e. Pleca of Injury - At homa, ferm, street, fectory, offica building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) efter 4 Homicide within 24 hours e To the Funeral I completely filled To the Hospital edical 1 Certifying Phyeiclen: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner as steted.
2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date and pleca, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) 29b. Signatura and title of certific 29c. Licanse number 29d. Deta signed (Month, Dey, Year)

State

31. Deta filed (Month, Dey, Year) Registrar

Javid



MD

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

Cuellar

Au4176435C8574

22 S. Greene Street

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Live th **Physician** 15,1997 Woodruff Tabb George, Jr. March 12:20 Am /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 36 Walden Oak Ct. Woodlawn Baltimore If Under 1 Year Months Deys If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Day, Year) 5. Sociei Security Number 7. Age (In yrs. last birthdey) **Funeral** Birthpleca (Stete or Foreign Country) 1 M 2□F Yrs Director 217-64-2345 31, Oct. 1951 Maryland Usuel Residence of Decedent the Marylend 10e. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinat insist be notified as 1 Yes No MD BAltimore Woodlawn Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 36 Walden Oak Ct. 21207 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. permit. Pages 1 end 2 should be filed within 72 hours after of Department of Health and Mental Hygiene, innortant: if Itam 27 is marked other than "natural, or iten any injury or other traumatic event, the Medical Experiments." Bleck, White, etc. Never Married 2 Married 1 ☐ Yes No Specify: à Specify: White ☐ Widowed 4 ☐ Divorced Yeer or Dates: Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Chimes School Chimes School 10 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Woodruff Tabb George Heningham Fulton 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zlp Code) 2 1 2 0 4 19e. Informent's Neme/Reletionship (Type, Print) 1815 Thornton Ridge Rd., BAltimore, MD A.C. George/ Brother 20a. Method of Disposition

1 □ Burial 2 Cremation 3 □ Removal from Stete
4 □ Donetion 5 □ Other (Specify) 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Dete Druid Ridge Cemetery 3-17-97 Pikesville, MD 21. Signature of Funerel Service Licensee 22. Neme end Address of Fecility Henry W. Jenkins & Sons Company 4905 York Rd., Baltimore, MD 21212 Part. Int the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or pent feilure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate se (Finel disease or condition resulting in death) Seigure /Medical Minutas Examiner Due to (or as e consequence of): Examiner end I-transit that the death certificate be executed Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): physician er is the buriel-t Physician/Medical Due to (or es e consequence of): for use as 88 Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yee 2 No 3 Probably Wunknown signed I þ The jaw requires Completed 24b. Were autopsy findings 24e. Wes en eutopsy aveilable prior to completion of cause of deeth? performed? page 2 s has utificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: 1 | Inpatient | 2 | ER/Outpetient | 3 | DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1. Netural 5 Pending investigation 1 Yes 2 No 2 Accident 8 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide P at D To the Hospital within 24 hours a To the Funersi Compietely filled edicai Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, dete end place, and due to the ceuse(s) end menner steted. 29a. Certifler (Check only one)

State Registrar

V

29b. Signeture end title of certifier

31. Dete filed (Month, Day, Year)

Mark

MAR 18 1997

Lamis

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK LAMOS M.D. 3505 HAMPSHIEE 6CEN CT, PHOEN IX 32. Registrer's Signature

MD

his Varidoon-Randalle

29c. License number

D34521

29d. Dete signed (Month, Day, Year)

2113 1

3-16-97

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Records, P.O. Box 68760.

Vita

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death **Physician** Month 1:02 AM **BENJAMIN** MAR **GOLDBERG** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring I Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Holy Cross Hospital Montgomery 5. Social Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 10XM 2□ F Yrs. Director 215-38-4281 August 14, 1915 New York Usual Residence of Decedent deeth with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic evant, the Medical Examiner must be notified at 1 Yes 2 No Director Silver Spring 10f. Zip Code Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 5 Itams 23a 10820 Margate Road 20901 Funerai U.S.A.

14. Race - American Indian,
Black, White, etc. 12. Was Decedent Ever in U,S.
Armed Forcas?

1 X Yes 2 □ No
If Yes, Give
Year or Dates: W W 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 end 2 should be filed within 72 hours after of health and Mental hygiene.
ant: If Item 27 is marked other than "natural", or item yor other traumals event, fire Medical Exert any or other traumatic event, fire Medical Exert any 1 ☐ Naver Married 2 Married 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Department Of Elementary/Secondary (0-12) College (1-4or 5+) Agriculture 4 Years Budget Analyst Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jacob Goldberg Lena (Unknown) 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois A. Hollander, Daughter 5238 Farm Pond Lane, Columbia, Maryland 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3/12/1997 20c. Location - City or Town, State 1XXBuriel 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Adelphi, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mount Lebanon Cemetery 21. Signature of Funerel Service Licensee 22. Name and Address of Facility STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012

Approximate shock, or heart failura. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical tmmediete Ceuse (Finet Sepsis 2 weeks disaasa or condition resulting in death) **Examiner** Due to (or as a consequence of) 2 weeks aw requires that the death certificate be executed Sequentielly tist conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ettending physician for use as the buria week Physician/Medicai 2 weeks intestinal Obstruction Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Intestinal Adlasions g 90 24b. Wera eutopsy findings available prior to pleted 24a. Was an autopsy performed? completion of causa of death? 1 Yas 2 ₽No 1 Yas 2 No 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred spital or Attending Prious after death.
neral Director: After the filled in by the funers Certification: 5 Pending investigation 1 Matural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the ceuse(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of cartifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) 024571 morch 11, 1997 em m0 30. Name and addless of person who completed ceuse of death (Item 23a) (Type, Print) 11501 Georgia Wheeler und 20902 Jev AJL Weiner

32. Registrar's Signature

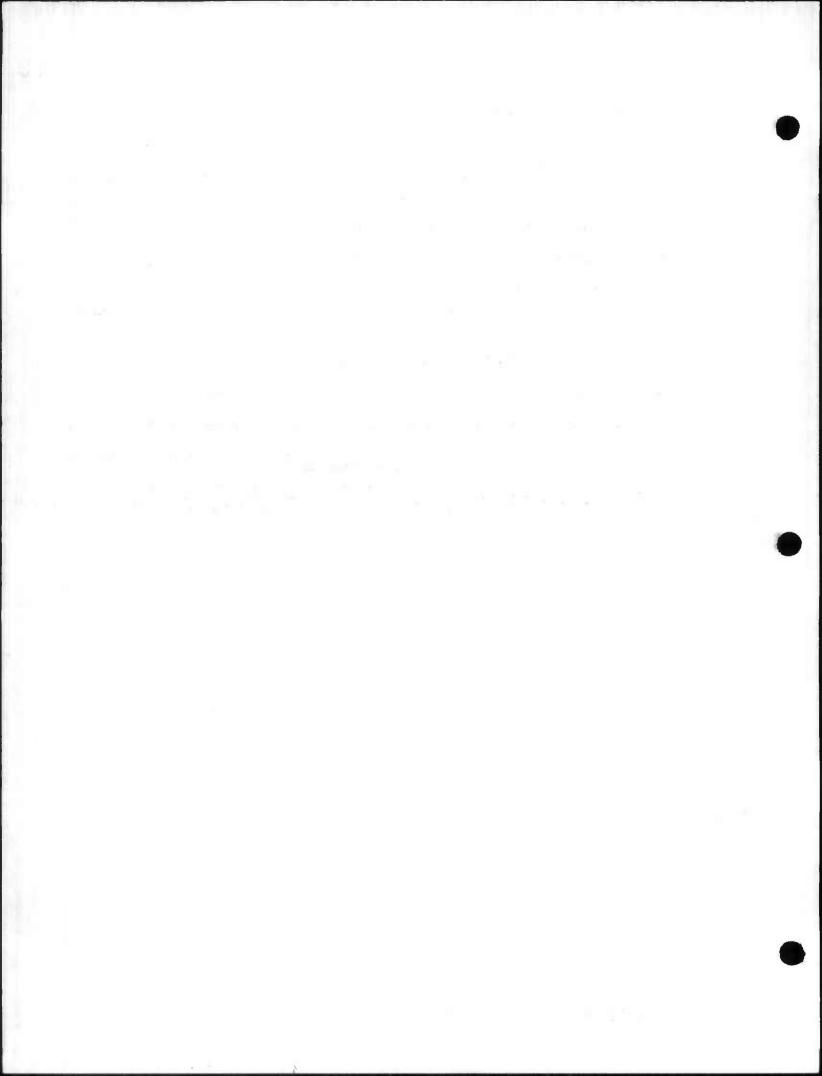
DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

MAR 18 1997



State of Maryland / Department of Health and Mental Hygiene 97 08111

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	Obverie		Decedent's Name (First, Middla, Last)								2. Date of Death Month Day Year			3. Tir	ne of Death	
	Physic /Medi		Robert ROSS HEARD)				March 14, 19		-			:00 am
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	and **		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d.									Od Insi	de City Limits			
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Baltimore,	artm ortan injur		21. Signature of Fu					22. Name and Add	dress							
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DIVISION	fred fred of n by	E	3 ☐ Suicide 8 ☐ Could not be determined 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify)							28f. Location (Streat and Number or Ruraf Routa Number, City or Town, Stata)						
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth **Physician** Month Ronald Hunter 2:00 AM March 97 12 /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** St. Agres Hospital BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number if Under 1 Yeer 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** Sex 1 1 M 2 □ F Deys Yrs. 217-80-5024 42 Director 17, 1954 Marylow Usuei Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or items 23e or 28e-f shov traumstic event, the Medical Exami ne main be notified at 1 Tes 2 No Director BALTIMERE Mary Low 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 604 LENNOX STREET 2/2/7 USA deeth v 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumatic event, it is Medical Exercises. 1 Dever Merried 2 Married 1 Yes 2 4 No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 → No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Block 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementery/Secondery (0-12) DEVElopmentally DISABLED College (1-4or 5+) UP 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) extel Hunter 19a. Informant's Neme/Reletionship (Type, Print) RMELA GRAYSON (CHIMES) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Gray son 4815 Scten Drive BALTIMOR, Maylows 21315 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removei from State Mt. Lion Comstany BALTIMORE MANY COUS 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility CHATMAN - HAMRIS FUNERAL HOME 52 40 REISTEN STUND ROWN 21. Signature of Funerel Service Licansee BAltimore, Haycoms 2/2-15 Belliucie, Harves 210-123e. Perty Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervai Between Onset end Deeth **Physician** /Medical Immediete Cause (Final diseese or condition resulting in death) Examiner Examiner PSis the buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest end Due to (or es e consequenca of) Ittending physician Box 68760 Physician/Medical Due to (or es e consequenca of): 98 980 0 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings evalleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Division of Vital Recor peed 2.18 No this certificate 1 ☐ Yes 2 No Attending Physician: 25. Wes case referred to medical examiner? 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 inpatient 2 □ ER/Outpetient 3 □ DOA 27. Menner of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Neturel 5 Pending investigation death. To the Hospital or Attendition within 24 hours efter death. To the Funeral Director: A completely filled in by the form 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Examiner: To the best of my knowledge, death occurred et the time, date and piece, and due to the ceuse(s) and menner as stated. Medical Examiner: On the best of examinetion end/or Investigetion, in my opinion, death occurred at the time, date end piace, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) MD March - 12 - 97 D506071

State Registrar

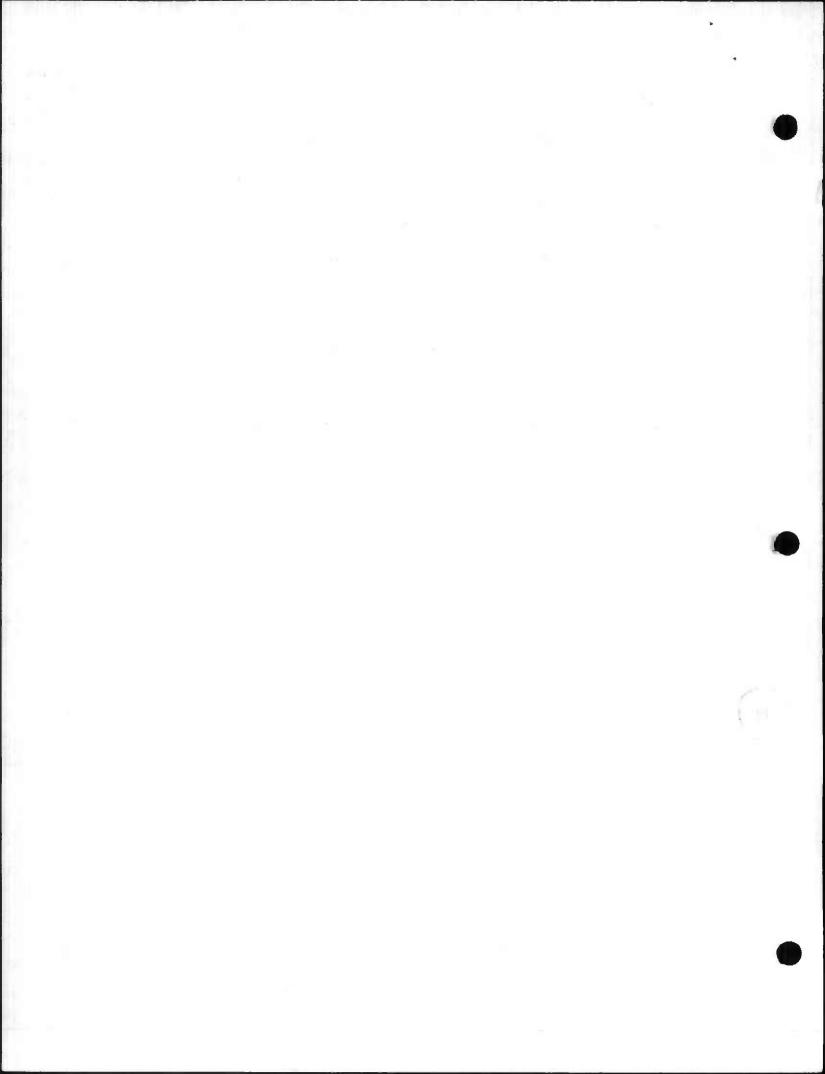
31. Date filed (Month, Day, Year) MAR 18 1997

Wafer Gamil 32. Registrer's Signature

of person who completed cause of deeth (Item 23e) (Type, Print)

Taidson-Randall

St. Agnes hospital



State of Maryland / Department of Health and Mental Hygiene

			State 0	-	Certificate of			. No. 9	7 08116			
	Dhysia	ion	Decedent's Nama (First, Middle, Last)				2. Data of Death Month	Day Ya	3. Tima of Death			
	Physic /Medi		JEFFERSON DAVID	HAIR			MARCH	15 199	7 0255 AM			
	Exami		4a. Facility Nama (If not institution, give street and nut	nber)		4b. City, Town, or Lo	cation of Death	4c. County of E				
			ST Hanes H	ospital			one	NI				
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	land		Usual Rasidence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. inside City Limits			
	the Marylan 28a-f show	ğ	MDNA			10 Yas 2□No						
	r 288	9	10e. Street and Number		4271100 1 10f. Zip Code		100	. Citizen of Wha	t Country?			
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e,	ges 1 end t of Health if item 27 or other tr		20a. Method of Disposition	20b. Place of	Disposition (Name of	SAIIMO	Date 20	c. Location - City	y or Town, State			
JUO T	00-		1 Burial 2 □ Cremation 3 □ Ramoval from 4 □ Donation 5 □ Othar (Specify)	State	, crematory or other place	00)	-19-07/	10.00				
Baltimore,	-545		21. Signature of Funaral Service Licensaa		22. Name and Addra	ss of Facility	176	my don	me, mo			
m	permit. Departi		638 N. Wilher Siver									
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between									
88	Physician		shock, or heart failura. List only one cause on e		intarval Between Onset and Death							
	/Medical		Immediate Cause (Final disease or condition Rew days									
	Examiner		resulting in death) Due to (or as a consequence of):									
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	cate be executed physician and sthe burial-transit	Examiner	Sequentially list conditions,	Due to (or as a consequence of):								
68760,	ie death certificate be executed the attending physician and thed for use as the burlat-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury									
587	g phys as the	edical	that initiated events resulting in death) Last	Due to (or as a co	onsequenca of):							
Box	attending for use a		d									
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o uo	ding Physics. After this funeral di		27. Manner of Deeth 28a. Date	of Injury 28b. Ti	me of 28c. Injury		28d. Describe how		Specify)			
Division	or Attendation after death Director:	Certification:	3 Suicide 6 Could not be	of Injury - At home, fari ng, etc. (Specify)	m, street, factory, office		281. Location (Stre City or Town,	ion (Street and Number or Rural Route Number, r Town, State)				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C	(Check only 2 Medical Examiner: On the ba	best of my knowledge, asis of examination and her stated.	deeth occurred et the tin for investigation, in my o	me, dete end place, a pinion, death occurr	, and due to the cause(s) and manner as stated. rred at the time, date and plece, end due to the cause(s)					
	To the Fo the comp	Me	29b. Signature and title of certifler		29c Licens				fonth, Day, Year)			
			(Whitevarion Et	AHENDIN	6 D4	035%	14	ARCH	15,1997			
			30. Name and address of person who completed ceus WENGUAT NAVAULO	a of death (Item 23a) (7	Type, Print) CATOM AVE	BAITH	UORE I	LI AD XI	15,1997 AND 21229			
	Sta	te	31. Data filed (Month, Day, Year) 32, R	egistrar's Signature	90,017 111-0	1/610111		1/1/-/ 4				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Rubin rsc 3 /Medical 4e. Fecility Neme (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Silver Spring Holy Cross Hospital If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Months, Day, Year) June 12, 1 5. Sociel Security Number 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) **Funeral** 180 M 2□ F Yrs 1905 New **Director** 91 089-05-8830 Usual Residence of Decedent with the Maryland 10a, Stete 10b. County 10c. City, Town or Location itam 27 le marked other than "natural", or itema 23a or 28a-f ahow other traumatic event, the Medical Examiner name be notified at 10d. Inside City Limits Maryland Montgomery Silver Spring 1 Yes 2 No Director 10e. Street and Number 10f. Zln Code 10g. Citizen of What Country? 20910 U.S.A. 1316 Fenwick Lane, Apt. 1116 death Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Meritei Stetus Bieck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours effer. Department of Health end Mental Hygiene. Important: If Itam 27 is marked other than "natural", or ite, any Injury or other traumatic event 1 ☐ Yes 2 ② No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 200No p Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Years Pharmacist Drug Store 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) Be Nathan Hirsch Clara Gutnick 2 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Carl M. Hirsch, Son 114 Hedgewood Drive, Greenbelt, Maryland 20770 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Pinelawn Long Island Dete 3/16/1997 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Beth Moses Cemetery New York 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecil STEIN HEBREW MEMORIAL FUNERAL HOME, INC. Donald (232 CARROLL STREET, N.W., WASHINGTON, D.C. 20012 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) ears DISPUSE Par Examiner s a consequence of) Examiner hero 20 erosis attending physician and for use as the burial-transit the death certificate be axecuted Sequentielly list conditions, If eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es e consequence of): Box 68760, Physician/Medical Due to (or es e consequence of) resulting In deeth) Lest P.O. by the Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No hronic Records. p 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes en autopsy performed? Myasthenia 1 Yes 2 TNo 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2K™No Propertient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Certification: To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After it 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident the 6 Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end pieca, and due to the ceuse(s) and menner as steted. 2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. Medical 29e. Certifier pletaly (Check only one)

29c. License number

MO

(Item 23e) (Type, Print)

29d. Dete signed (Month, Day, Year)

20962

97

State Registrar

29b. Signeture and title of certitier

10313

30. Name and address of person who completed cause of beeth (

Georgia

Are

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Hahn Month Kobert March /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Fallston General Hospital Fallston Harford 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign Country) Bronx, New York **Funeral** Days 123-12-5113 Yrs. Director Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🔯 No Director Maryland Baltimore Kingsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5 11608 Mohr Road 21087 Nems 23a U.S.A. by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Merried 2 TX Married 1 X Yes 2 □ No If Yes, Give 1941–1942 Year or Detes: 21215-0020 9 1 Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced "natural", White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic evene section." Elementery/Secondary (0-12) College (1-4or 5+) 12yrs. 4yrs. Draftsman Baltimore County Md. 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) Be Albert Hahn Wilhelmina Herdtfelder 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Emma M. Hahn (Wife) 11608 Mohr Road Kingsville, Maryland 21087 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State XX Burlel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Fork Meth.Church Cem. 3/17/97 Fork, Maryland 21. Signature of Funerel Service Licens 22. Name end Address of Fecility
E. F. Lassahn Funeral Home 11750 Belair Road Kingsville, Md. 21087 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner lew requires that the death certificate be executed **burial-transit** and Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequenca of) Records, P.O. Box 68760, signed by the attending physician Id be detached for use as tha buria Physician/Medical Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? DRONARY 1 Yss 2 No 3 Probably 4 Unknown à Be Completed 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Was an eutopsy performed? peed 1 Yes 2 No 1 ☐ Yes 2 1 No Division of Vital 25. Wes case referred to medical 28. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. fnjury et Work? Certification: 28b. Time of 28d. Describa how Injury occurred or Attending 5 Pending investigation 1 Natural death. To the Hospital or Attendity within 24 hours after death.
To the Funeral Director: A completely filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and placa, and due to the cause(s) and manner as steted.
2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end placa, end due to the cause(s) end manner stated. Medical 29a. Certifier (Check only 29b. Signeture and title certifier 29c. License number 29d. Dete signed (Month, Day, Year)

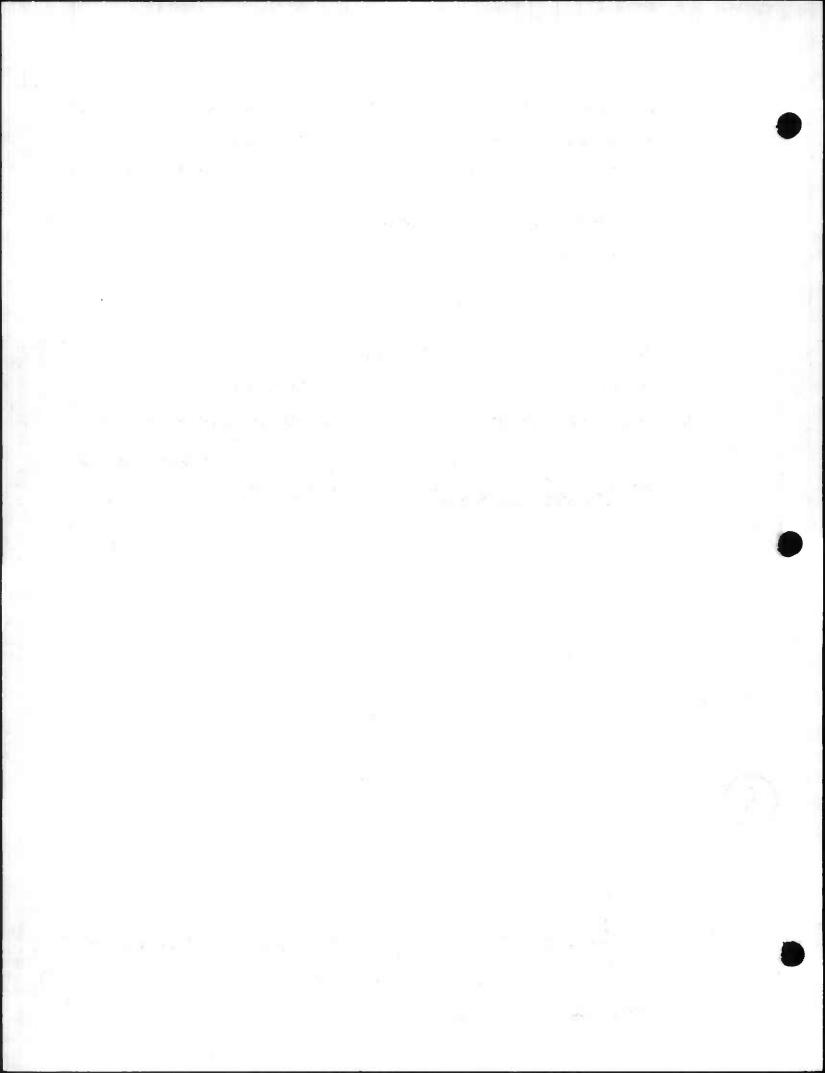
State Registrar

31. Date filed (Month, Day, Year)

MAR 18 1997

VIJAY. S. NAIR M.D. 2112 Belan Road. 32. Registrar's Signature un Davidson-Randalle

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death P. Helm Month Harry 03 12 97 8:10pm 4e. Facility Neme (If not institution, give street end number) 4b City Town or Location of Deeth 4c. County of Death Caroline Nursing Home Denton Caroline If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 10 M 2□ F Deys 056-01-7654 98 Yrs. 07/25/1898 Stanley, New Jersey Uauel Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland 1 Yes 2 No caroline Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 520 Kerr Avenue 21629 U.S.A. 11. Maritel Stetus Wes Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried Specify: White 1 ☐ Yes 2 No Specify: 3 Nidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Buainess/Induatry Multi-national (Specify only highest grade completed) Elementery/Secondery (0-12) Coilege (1-4or 5+) Communications Corp. Service Technician 17. Father's Name (First, Middle, Last) 18. Mother'a Neme (First, Middle, Melden Surneme) Harry P. Helm Emna Burk Larot 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Wanda S. Davis 32 Pine Reach - Rehoboth Beach, DE 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriei 2 M Cremetlon 3 ☐ Removel from State Capital Crematory Services 03/14 5 ☐ Other (Specify) Dover, Delaware 4 Donetion ine of Funera Vivio Lid 22. Name and Address of Facility al Home-202 Laws Street Bridgeville, DE 19933 23e. Pert1. Enter the disease, or complications that cause the deeth. Do not enter the mode of dying, auch ea cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on each file. Approximete Intervai Betw Onset end Death immediate Cause (Finel disease or condition resulting In death) Preumonia weck Due to (or as e consequence of); Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or ea a conaequence of): Due to (or es e consequence of): Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Renal Failure 1 Yes 2 No 3 Probably 4 Nunknown 24b. Were autopay findings aveilable prior to completion of cause of death? Iron Deficient Anemia 24e. Was an eutopsy performed? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Examiner The law requires that the death certificate be axecuted physician and the burial-transit

been signed by the a should be detached

Vital Records, P.O. Box 68760

Physician/Medical Examiner

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Completed

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Certification: To

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Physician /Medical

Physician

/Medical

Examiner

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Funeral

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Completed

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental hyglene.
Instit if ten 27 le marked other than "natural", or Items 23e or 28e-f show mix! if item 27 le marked other than "natural", or India 28 or 28e-f show mix! or India 28 or 28e-f show mix! or other traumate event, its Medical Esamine must be notified at

Baltimore, Maryland 21215-0020

7 is marked other than "natural", or flams 23a or 28a-f show traumatic event, the Medical Examinet must be notified at

Department of Important: If it any injury or o price.

25. Wes case referred to medical examiner? 1 ☐ Yes 25 No 27. Manner of Deeth

5 Pending Investigation 6 Could not be determined 28e. Dete of Injury (Month, Dey Year)

28b. Time of

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1 Neturel 2 Accident

3 Sulcide

4 Homicide

1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and plece, and due to the cause(s) end menner stated.

29c. License number

29b. Signature and Alfo of certifier

29d. Dete signed (Month, Day, Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Donton, red 21629

State Registrar Hob Lappin mt
31. Dete filed (Month, Day, Year) MAR 18 1997



24 hours

To the Hosp within 24 hos To the Fun-

			State of Mary		tificate of		, ,	eg. No.	97 (08120				
	Physici /Medi		Decedent's Name (First, Middle, Last) Charles Edward	l Johnso	n		2. Date of Deat Month March	Day	Year 1997	3. Tima of Death 9:45 at				
1	Examir		4a. Facility Neme (If not institution, give street end number) 3700 Greenspring Ave., Apt. 5	505	4b. City, Town, or L Baltin			h 4c. County of Death N/A th 9. Birtholaca						
020	Funeral Director	П	215-54-2993 1XM 2□F	7. Age (In yrs. last birthday) 48 Yrs. 7. Age (In yrs. last birthday) 48 Yrs. 15. Under 1 Year Months Deys		1f Under 24 Hrs. Hours Min.	8. Date of Birth			npiaca (State or Foreign				
	Maryland Ff show	tor	Usual Residence of Decedent 10a. State N/A 10b. County 10b. Count	Oc. City, Town or Loc Baltimo	cation				10d.	Inside City Limits				
	h with the 23a or 28a	Funeral Director	10e. Street and Number 3700 Greenspring Ave. Apt. 50	05	10f. Zip Code	10g. Citizen of What Country? USA			7					
	d within 72 hours efter death with the Maryland jiene. I than "naturel", or ferma 23a or 28a-f show tr than "naturel", or ferma 23a or 28a-f show tre Medical Examiner must be notified at	by	11. Marital Status 12. Was Decedent Ever Armed Force? 1 Yes 20 No If Yes, Give Year or Datas:	Was Decedent Ever in U,S. Armed Force? 1 ☐ Yes 2 ☐ No If Yes, Specify Cub 1 ☐ Yes 2 ☐ No Year or Datas:		dispanic Origin? (Spe an, Mexican, Puerto i Specify:	14. Race - American Indian, Black, White, etc. Specify: Black							
21215-0020	within ene. than	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)		Decedent's Usual Occupation (Give kind of work done during most of workin, life. DO NOT use retired) nancial Planner			Person	Businass/Industry onal Financial ervice					
Maryland 2	wild be file Mentel Hys arked othe atic event,	To Be C	17. Father's Nama (First, Middle, Last) Albert Johnson, Sr. 19a. Informant's Name/Ralationship (Type, Print)				ie Carri	e Smith						
Baltimore, Mar	Health er lam 27 le other treu		Keevie C. Johnson/Mother 20a. Method of Disposition 2	3306 20b. Place of Dispos	N. Hilto	on St. Bal	timore,							
Balti	permit. Pages Depertment of Important: If it any Injury or sance.		21. Signeture of Funeral Servica Licensee George E. MacNabb		and, Inc.									
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)	deeth. Do not ente	er the mode of dyir	ng, such es cardiac d	r respiratory arre	est,	A	pproximete itarval Between inset end Death				
x 68760,	aath certificete be executed ettending physician and for use es the buriel-transit	Completed by Physician/Medical Examiner	if eny, leeding to immediate cause. Enter Underlying Cause (Disaasa or Injury that injury deposits of the control of the contr	a to (or as a consequ										
s, P.O. Box	that the de ed by the detached		by	by			Part II. Other significant conditions contributing to death but no	ot resulting In the un	nderlying cause giv	ause given in Part I. 23b. Did tobacco use contribute to the cause of de				
Becords,	her been sign									24a. Was an autopsy performed? 24b. Were eutops available pric completion of death?		able prior to eletion of cause		
Z	Ry	Be	25. Was case rafarred to medical examiner?	2 ER/Outpatiant	Oth	26. Place of Death			1 🗆 Y	ras 200 No				
Division of	al or Attending Physics after death. A Director: After this ed in by the funeral at	Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 27. Manner of Death 1 Classification 2 Accident 3 Suicide 4 Homicide 1 Inpatient 28a. Data of Injury (Month Dey Year (Month De	28c. Injur Wor	1□ Yes 2 No U/A				ioute Number,					
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifiar (Check only one) 1 CertifyIng Physician: To the best of my delical Examiner: On the best of examiner and manner stated. 29b. Signatule and title of celulier	mination end/or inv	occurred at the tirestigation, in my o	oplnion, death occurre	ed at the time, da	use(s) and ma ate and place, ed. Dete signe	and due to th	ne cause(s)				
	241			Can. (Itam 23a) (Type, F	D4!	5925 5 Medica	al Canta	03-1	7-9	iŦ				
	Sta	te	31. Date filed (Month, Day, Year)	Signaffice Con	2600 L	iberty He	ight Ave	. Balti	mor Mi	121215				

E.O. J. A.

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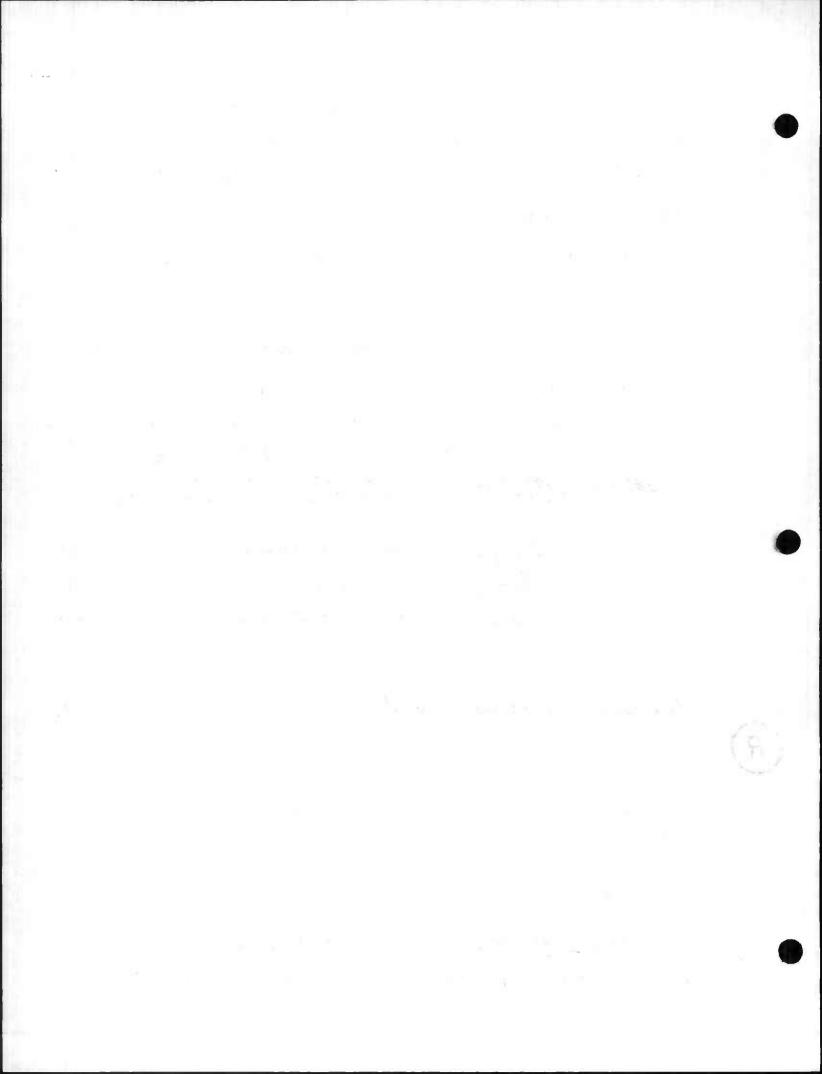
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physiclan** Month March 15, **Allyce** 1997 Cathryn Johnson 12:55 PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Chesapeake Manor Extended Care Center Arnold Anne Arundel 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** 1 ☐ M 2 🕱 F 83 Months Deys Yrs. Director 213-46-7831 MAR 25, 1913 Texas the Maryland 10a State 10h County 10c. City, Town or Location ns 23a or 28a-f show must be notified at 10d. Inside City Limits Anne Arundel Director 1 Yes 2 No Annapolis 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1365 Linden Avenue Funerai 21403 USA itams : 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. r than "natural", or itan the Wedisal Examiner filed within 72 hours efter 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 ☐ Divorcad Specify: Black Be Completed 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Teacher/Administrator Pages 1 and 2 should be filed with the period of Heelth and Mental Hygien tant; if itam 27 is marked other the jury or other traumatic event, that Public Schools altimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Samuel E.J. Watson Lena B. Thomas 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 s Department of Heelth ar Important: if Itam 27 is any injury or other trau Ed Lee Johnson/son 1359 Linden Avenue Annapolis, MD 21403 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other placa) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Removel from State Metro Crematory, Inc. 3/17/97 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 21. Signeture of Funeral Service Licensee Cremation Society of Maryland, Inc. George E. MacNabb 299 Frederick Rd. Baltimore, MD 21228 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death Physician /Medical immediate Ceuse (Finel diseese or condition resulting in deeth) Examiner Physician/Medical Examiner at the death certificate be executed buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Due to (or es P.O. Box 68760. the Due to (or es e consequence Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were autopsy findings aveilable prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1□ Yes 2 No 1 ☐ Yes 2 ☐ No certificalle Division of Vital Attending Physician: Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Surring Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this the funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Certification: 28c. Injury et Work? 28d. Describe how injury occurred After 1 Naturel 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a, Certifier 12 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

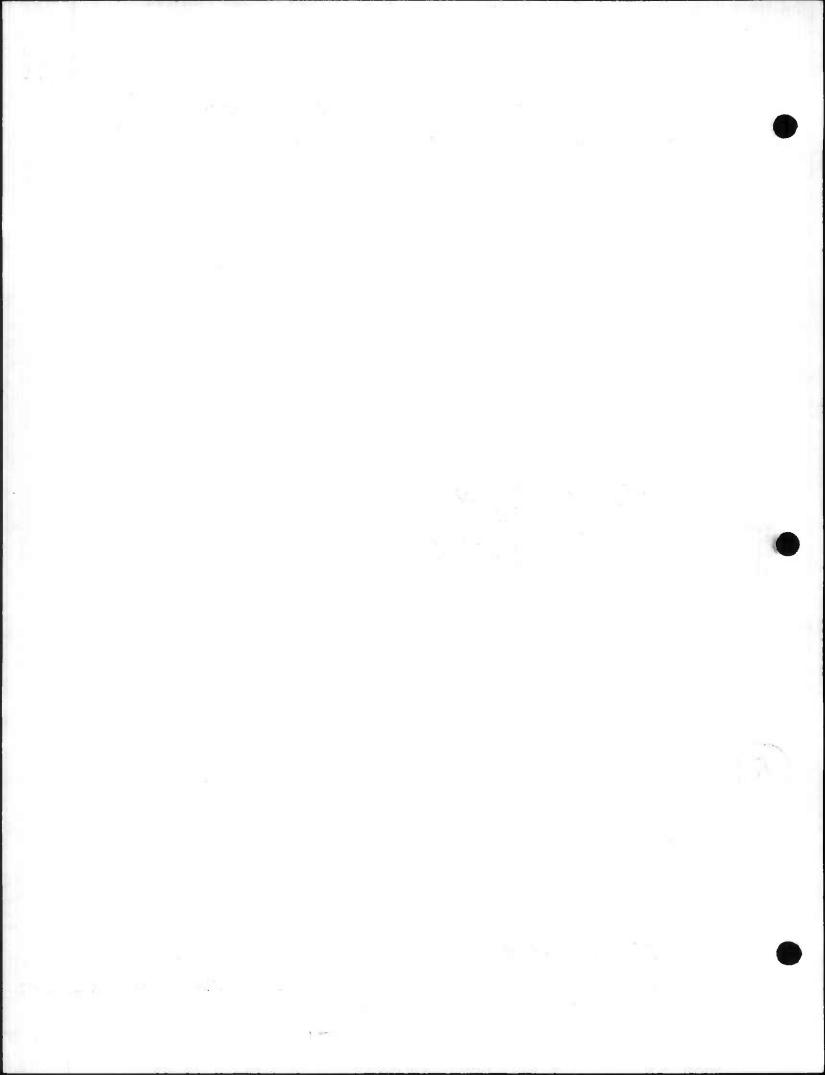
2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) ymac M1 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) PASADRNA C.V. LYRIAC. M.D 8109 RITCHIR BUT, 31. Dete filed (Month, Dey, Year) 32. Registrers Signature Randall State MAR 18 1997 Registrar



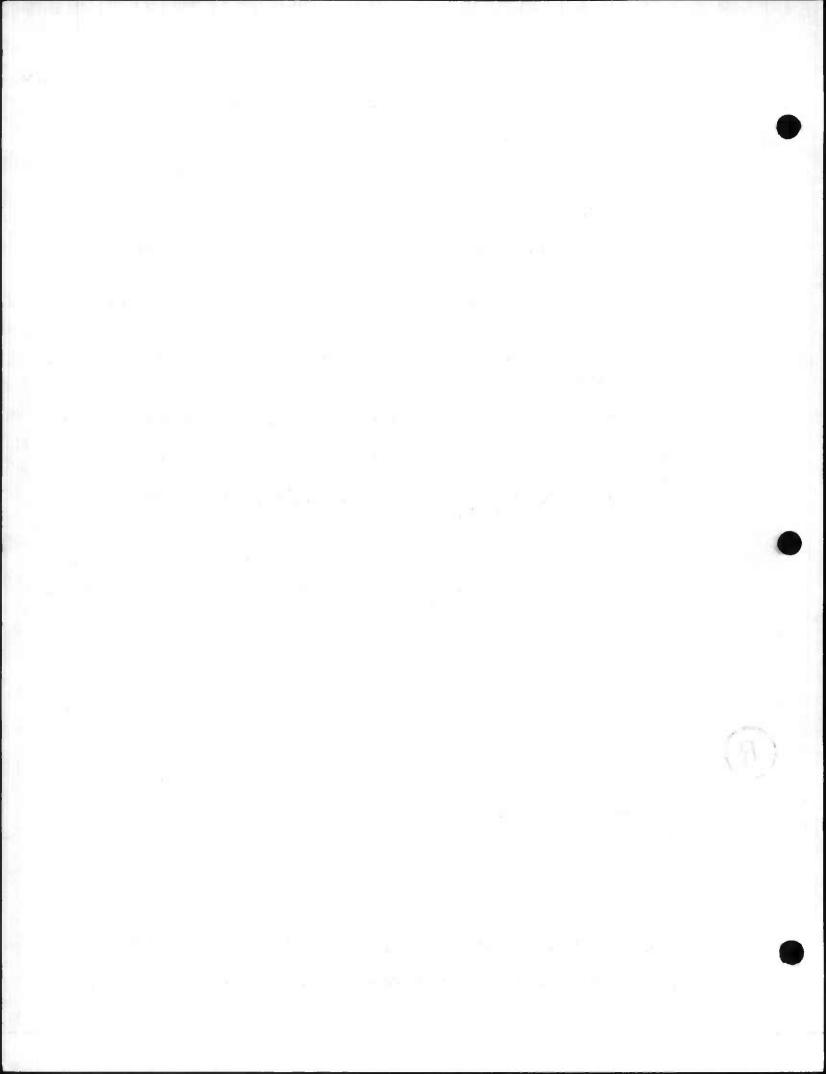
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth Month **Physician** Yee CAROLE KATTES MARCH 13 1997 5:00P.M. /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Davs Hours Min. (Month, Dey 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplece (State or Foreign **Funeral** 1 M 2 F Months 205-50-4422 Yrs. 01/01/1959 Darby, Director Usuei Residence of Decedent with the Merylend 10e. State 10b. County 7 is marked other than "naturel", or items 23e or 28a-f show traumstic event, the Medical Exeminer must be notified at 10c. City. Town or Location 10d. Inside City Limits Frederick MD Frederick Director 1 □ Yes 2 No 10f. Zip Code **21701** 10e. Street end Number 409 W. 10g. Citizen of Whet Country? Patrick Street U.S.A. death y Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ Io If Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Maritel Stetus hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ♣No Specify: þ **Black** 3 Widowed 4 Divorced Completed se filed within 72 hall al Hygiene. 15. Decedent's Education 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) In Home Elementary/Secondery (0-12) College (1-4or 5+) Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be permit. Pages 1 and 2 should be Department of Health end Mental Important: If item 27 le marked o any Injury or other traumatic eve James Ruley Mildred Smith 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stele, Zip Code) 19036 Mildred Murray 100 E. Glenolden Ave., #P11, Glenolden, PA 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ♣ Removel from State Mt. Lawn Cemetery 3/17 Sharon Hill, PA 4 ☐ Donetion 5 ☐ Other (Specify) LEROY O. DYETT & SON FUNERAL HOME, P.A. 21. Signeture of neral Service Licenses d he deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner bue to (or es e consequence of): Examiner buriel-transit and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequence of) P.O. Box 68760. attending physician for use es the burie ires that the death certificate be Physician/Medical thet initieted events resulting in deeth) Lest 100 Due to (or es e consequence of): USB BS Pert II. Other significant conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? à 4 Unknown 1 ☐ Yee 2 ☐ No 3 Probably ds þ Completed 24e. Wes en eutopsy 24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 2 🗆 No 2 \ No 25. Wes cese referred to medicel exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: To 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Division of this 28a. Dete of Injury (Month, Dey Yeer) 27. Menner of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred After Certification: Attanding Natural 5 Pending investigation s efter death.
I Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 - Homicide To the Hospital of within 24 hours of To the Funeral D 1 Certifying Phyeiclan: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted. Medicai (Check only 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name end eddress of person who completed cause deeth (Item 23e) (Type, Print) O.C.M.E. MARCH 15, 1997 THEODORE MIKE-111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Dete State Registrar



				Cei	rtificate of	Death		Reg. No.	97 1	18123	
Physic /Medi		Decedent's Neme (First, Middle, Last DONALD)		KRIDEN	OFF	2. Dete of De Month MARCH	Dey	Year	Time of Death :42 P.N	
Examin Funeral Director		4e. Fecîlity Name (If not institution, give THE JOHNS HOPKINS 5. Social Security Number 213-32-0464 15	HOSPITAL	last birthday) Yrs.	If Under 1 Year Months Deys				N/A	(State or Foreign	
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n 72 hours efter death with the Meryland *natural', or frems 23a or 28a-f show soical Examiner mant be notified at	by	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorcad	12. Wes Decedent Ever In L Armed Forces? 1 by Yes 2 □ No If Yes, Give Yeer or Dates: Kore	ned Forces? If Yes, specify Cube			ecify Yes or No Rican, etc.)	Bleck, White, etc. Specify: White 16b. Kind of Business/Industry Bethlehem S			
within ene. then	Completed	15. Decedent's Edu (Specify only highest grad Elementery/Secondary (0-12) 12 17. Fether's Name (First, Middle, Last)	cation e completed) College (1-4or 5+)	(Give life. L	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Fire Bricklayer						
12 should be filed hend Mental Hygi is marked other traumatic event,	To Be	17. Fether's Name (First, Middle, Last) Jesse Kridenoff 18. Mother's Name (First, Middle, Maiden Sumame) Lillian Hammerbacher 19e. Informent's Name/Relationship (Type, Print) Lawrence Kridenoff/brother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 280, 190) 8107 Old Philadelphia Rd., Rosedale, MI								de) 21237	
Peges 1 end 2 nent of Health nt: If item 27 is rry or other tra		20e. Method of Disposition 1 Durial 2 Cremetion 3 F 4 Donetion 5 Other (Specify)	20b. I	Pleca of Dispo	sition (Name of natory or other pla	ice)	Dete -17-97	20c. Location	City or Town.	Stete	
permit. Peges Depertment of Important: If it any Injury or o		21. Signature of Funerel Service License	Kella	22	Neme end Addr Cvach/Ro 1211 Che	ess of Fecility esedale Fu esaco Ave.	neral H Baltim	lome lore, MD	21237		
Physician /Medical Examiner bphysician and physician and stree private physician and physician and street physician and physici	edical Examiner	23e. Pent1. Enter the disease, or complications that caused may death. Do not enter the mode of dying, such as cardiac or respiratory errest, link shock, or heart feiture. List only one ceuse on each link. Do not enter the mode of dying, such as cardiac or respiratory errest, link shock, or heart feiture. List only one ceuse on each link. Do not enter the mode of dying, such as cardiac or respiratory errest, link shock, or heart feiture. List only one ceuse on each link. Do not enter the mode of dying, such as cardiac or respiratory errest, link shock, or heart feiture. List only one ceuse on each link. Do not enter the mode of dying, such as cardiac or respiratory errest, link shock, or heart feiture. List only one ceuse on each link. Do not enter the mode of dying, such as cardiac or respiratory errest, link shock, or heart feiture. List only one ceuse on each link. Do not enter the mode of dying, such as cardiac or respiratory errest, link shock, or heart feiture. List only one ceuse on each link. Do not enter the mode of dying, such as cardiac or respiratory errest, link shock, or heart feiture. List only one ceuse on each link. Do not enter the mode of dying, such as cardiac or respiratory errest, link shock, or heart feiture. List only one ceuse on each link. Do not enter the mode of dying, such as cardiac or respiratory errest, link shock, or heart feiture. List only one ceuse on each link. Do not enter the mode of dying, such as cardiac or respiratory errest, link shock, or heart feiture. List only one ceuse on each link. Do not enter the mode of dying, such as cardiac or respiratory errest, link shock, or heart feiture. List only one ceuse on each link. Do not enter the mode of dying, such as cardiac or respiratory errest, link shock, or heart feiture. List only one ceuse on each link. Do not enter the mode of dying errors									
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To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check only one) 2 Medicat Examinate Medicat Examinate Signature and title of certifier	ner: On the besis of exemine and menner steted.	etion end/or inv	29c. Licen	opinion, deeth occurr	red et the time,	dete end plece, 29d. Dete signe	end due to the	cause(s)	
30x,		30. Name end eddress of person who co	mpleted cause of deeth (Iter			eet bai	timore	ani	21287		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacadant's Nama (First, Middla, Last) 2. Data of Daath Month MildRed 4a. Facility Name (If not institution, giva street and number) City, Town, or Location of Death 4c. County of Death ary land n/a 5. Social Security Number 7. Aga (In yrs. last birthday) 6. Sax Birthplaca (Stata or Foreign Country) 1□M 2X F 76 Yrs. 220-01-6742 1920 Virginia Aug. 4 Usual Rasidance of Decadant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Md. 1 Yas 2 □ No n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 40 E. Poultney Street 21230 USA 12. Was Dacadant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☐ Yo If Yas, Giva Yaar or Datas; Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Navar Married 2 Marriad 1 ☐ Yas 2 ☐ No Specify: 3 Widowad 4 Divorced Specify: white 15. Decadant's Education (Specify only highast grade complated) 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Eiamantary/Sacondary (0-12) Collaga (1-4or 5+) 10 seamstress Misty Harbor 17. Fethar's Nama (First, Middla, Last) 18. Mother's Nema (First, Middla, Maidan Sumama) Thomas Christiana Jennatt Rubenstein 19a. Informent's Name/Ralationship (Type, Pnint) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) James A. King (Son) 40 E. Poultney Street Baltimore Md. 21230 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stata 1 Surial 2 ☐ Cramation 3 ☐ Ramoval from State MARCH Glen Haven Mem. Park 17 1997 Glen Burnie Md. 4 Donation 5 □ Othar (Spacify) 21. Signature of Funaral Sarvica Licensaa 22. Nama and Addrass of Facility McCully Funeral Home of South Balto 130 E. Fort Ave. Baltimore, Md. 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwaen Onset and Death SEPSIC Immediata Causa (Finai disaasa or condition rasulting in daath) CL. DIFFICILE TIS SECONDEAR Sequantially list conditions, if any, leeding to immadiate causa. Entar Undarlying Cause (Diseesa or Injury that Initieted avants rasulting In daath) Last Dua to (or es e consequança of) Dua to (or as a consaquanca of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the cause of death? ALZHEIMER! 1 Yss 2 No 3 Probably 4 Unknown DISEASE 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? CATCHEXIA 1 Yas 2 No 1 Yas 2 No 25. Was casa rafarred to medical 26. Piece of Deeth (Check only ona)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show the Maryle

23a

A LIP ò must be

2121

altimore, Maryland

Pages 1 and 2 should be nent of Health and Mental

marked

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Department of Health as important: If Item 27 is any injury or other trau

Director

by

Completed

Be

Physician/Medical Examiner bunei-transit the þ 8 Be Completed 2

or Attanding Physician: The law requires that the death certificate be executed

Box 68760,

P.O.

Records,

Division of Vital

the Hospital

this certificete filled in by the funerai Certification: 27. Manper of Death After 1 Naturel within 24 hours efter death. To the Funeral Director: A 2 Accidant 3 Suicida 4 Homicide Medicai 29e. Certifia: compietely

(Check only onel

1 Yas 2 No

6 Could not be

28a. Data of Injury (Month, Day Year) 5 Pending Invastigation

Hospitai: 1 Inpatiant 2 ER/Outpatient 3 DOA 28b. Tima of

28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Dascribe how Injury occurred 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete)

Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) end menner as steted.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier

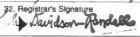
29c. License number

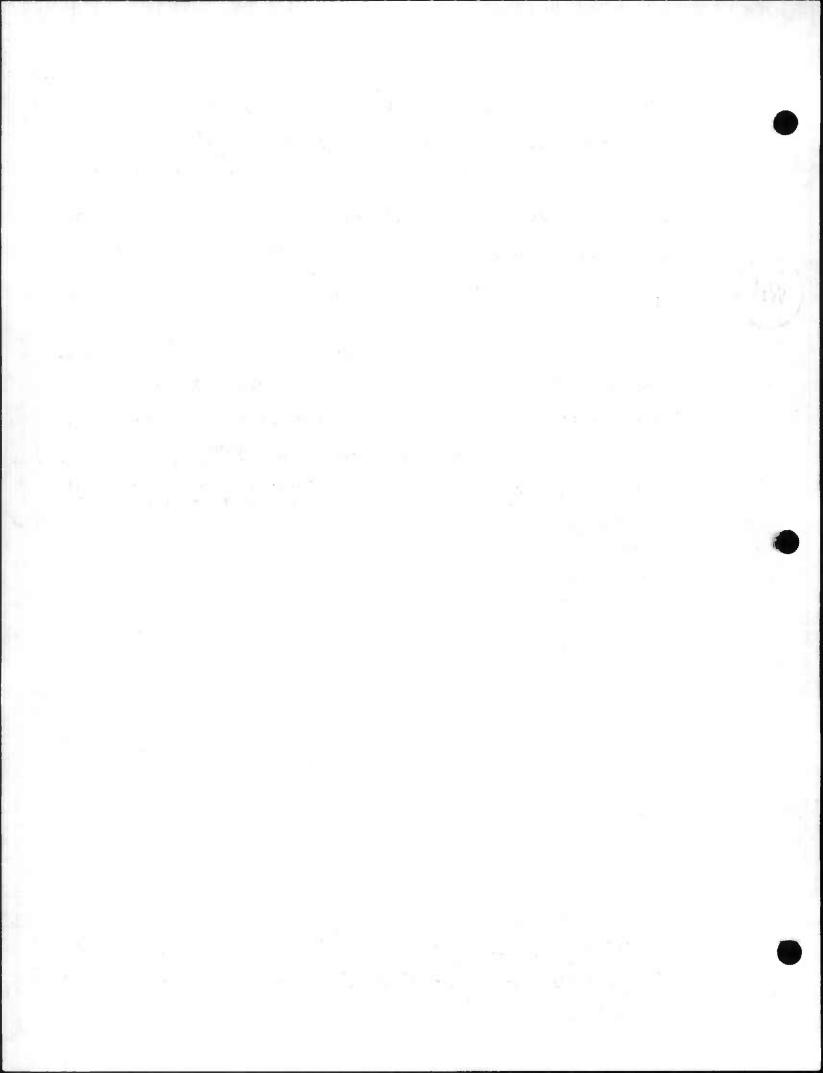
29d. Data signad (Month, Day, Year)

30. Nama and address of person who complated causa of daath (Itam 23a) (Type, Print) GRAYNOVSK

Pary land General Hospital

State Registrar 31. Date filed (Month, Dey, Year) MAR 1 8 199





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle Last) 2. Dete of Death 3. Time of Deeth 16 MARCH WILLIAM 1997 KELSEY KANE 8:27 AM 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death NORTH WEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE 5. Sociel Security Number If Under 1 Year 7. Age (In yrs. lest birthday) If Under 24 Hrs. 9. Birthplece (State or Foreign Country) PENNSYLVANIA 8. Dete of Birth (Month, Dey, Year) Months Deys M 2 ☐ F Hours Yrs. 215-28-4508 66 11/23/30 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND 1 ☐ Yes 2 No BALTIMORE RIDGELEIGH 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1848 YAKONA ROAD 21234 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Yeer or Detes: 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced white 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) 12th GRADE NEVER WORKED N/A 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) WILLIAM C. KANE ELEANOR KELSEY 19e. informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) KATHLEEN CARRICK 1848 YAKONA ROAD SISTER BALTIMORE, MD 21234 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) WOODLAWN CEMETERY 3/19/97 WOODLAWN, MD 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. Misleria 1101 ith. Do not enter the mode of dying, such as cardiac or respirelory errest. 23e. Pert1. Enter the disease, or complications that caused the shock, or heart feilure. List only one cause on each line Approximete Interval Between Onset and Deeth Immediete Ceuse (Finel disease or condition resulting in deeth) Due to (or es e conseguence of): Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of). Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 24b. Were autopsy findings evalleble prior to completion of ceuse Was an autopsy performed?

Physician /Medical Examiner

and

Records, P.O. Box 68760,

Vital

Division of

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Physician

/Medical

Examiner

10e. State

Funeral

Director

ms 23a or 28a-f show

Director

Funeral

Completed by

Be

the Maryland

Examiner Physician/Medical ģ Completed Be

The law requires that the death certificate be axecuted burial-transit attanding physician the for usa as signed by the at d be detached for cata has Certification:

after deal 2 within 24 hours a To the Funeral C complataly filled the Hospital

10

Medicai

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 22 No 1 ☐ Inpatient 22 ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Neturei 5 Pending investigation 1 □ Yes 2 □ No 2 Accident

3 Suicide 4 Homicide

6 Could not be determined

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29b. Signeture and title of certifier

† Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted. 29c. License number 29d. Date signed (Month, Dev. Year)

PC 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

D25112

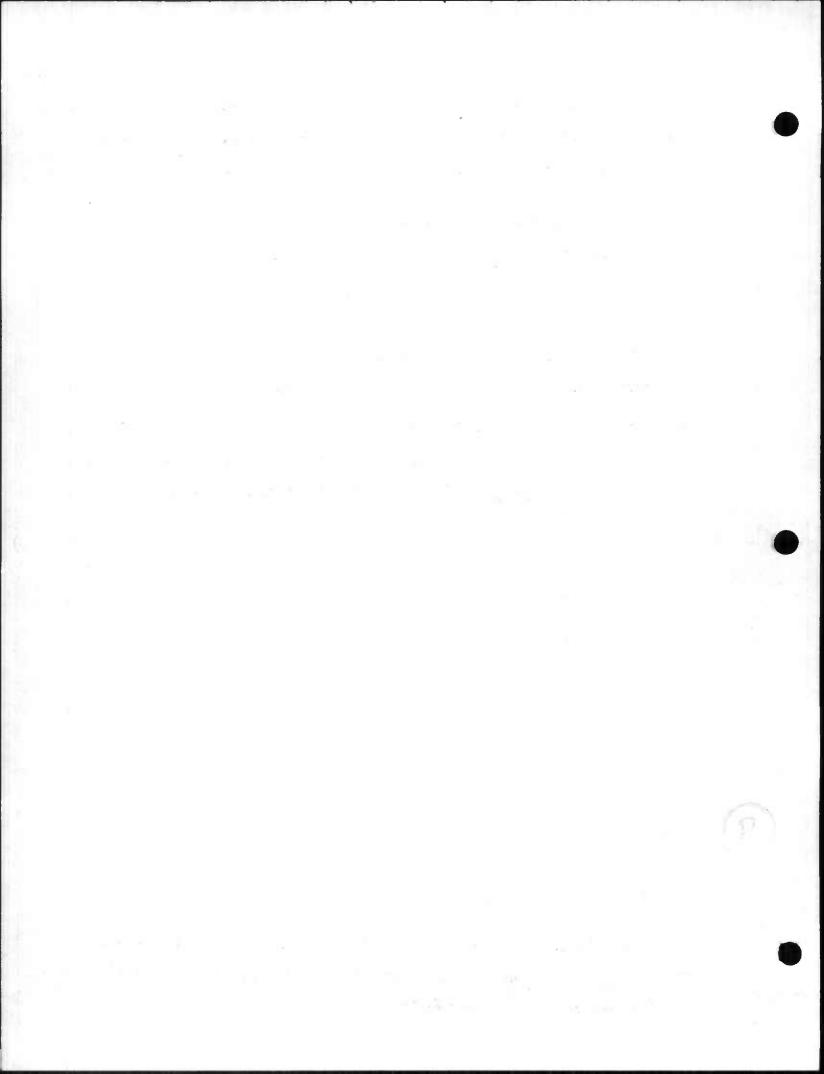
2 LPNo

5310 old Court Road KAWAJA

State Registrar

29e. Certifier

32. Repistrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decadant's/Nama (First, Middla, Last) tete of Daath **Physician** Month 03 /Medicai 6 4a. Facility Nama (If not institution, giva straat and number) 4b. City. Town, or Location of Death Mc. County of Death Examiner Harford NURSING HEALTH CENTER - RIVERSIDE BELLCAMP 7. Aga (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Sacurity Number 6. Sex 9. Birthplaca (State or Foreign Country) MARYLAND Funeral 1□M 2XF Months Days 217-18-5260 Yrs. Director Usual Rasidanca of Dacadant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumetic event, the Medical Examiner must be notified at HARFORD MD EDGEWOOD 1 Yes 2 No Director 10e. Street end Number 10f. Zip Coda 10g. Citizan of Whet Country? 6 MAGNOILA 1002 WOODS LU U.S **Нетв** 23a Funeral 12. Was Dacadant Evar in U,S. Armad Forcas? 1 ☐ Yes 2 M No If Yas, Giva Yaar or Detes: Was Dacedent of Hispenic Origin? (Spacify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - American Indian, Black, Whita, etc. 11. Maritel Status 1 Navar Married 2 Married 9 1 □ Yas 2 No Specify: Specify: WHITE by 3 Widowad 4 □ Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important. If them 27 is marked other than "natural". Completed 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Security SOCIAL Elementary/Secondary (0-12) Collage (1-4or 5+) CLERICAL ADMINISTRATION 17. Fathar's Nema (First, Middle, Last) 18. Mothar's Name (First, Middla, Maiden Surnama) Be JOS WACEK ANNA STEPHANCK 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) MARIE KALENDEK-DAUGHTER 1002 H. MAGNOLIA WOODS LN. EDGEWOOD MD21040 20b. Place of Disposition (Name of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 K Buriai 2 ☐ Crametion 3 ☐ Removal from Stata GARDENS OF FAITH 4 ☐ Donetion 5 ☐ Other (Spacify) 21. Signature of Funarai Sarvice Licenses 22. Nama and Address of Facility Home of Dundal K Part: Inter the disease, in complications that caused the death, no not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. Lich only one cause on each line. **Physician** /Medical Immadiata Cause (Final disease or condition resulting in death) Examiner Dua to (or es e consequança of): Examiner physician and s the burlal-transit Sequantially list conditions, if any, leeding to immadiate causa. Entar Undarlying Cause (Diseasa or Injury that initiated avents rasulting in death) Last Dua to (or as a consequence of): Physician/Medicai Dua to (or as a consequanca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? gned by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ Be Completed 24b. Wara autopsy findings avellable prior to completion of causa of daath? 24e. Wes an autopsy performed? 1□ Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminer? 26. Placa of Death (Check only ona) To the Hospital or Attanding Physician within 24 hours after death.

To the Funeral Director: After this certil completely filled in by the funeral directs. Other: 4 Other (Specify) 1 ☐ Yes 2 XNo Medical Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury et Work? Naturai 5 Panding Invastigetion 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be datarmined 3 Suicide 28a. Place of injury - At homa, farm, straat, factory, office building, etc. (Specify) 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, dete and piece, end due to the cause(s) end mennar es stated.

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and mennar stated. 29a. Certifier

altimore, Maryland 21215-0020

P.O. Box 68760,

rds.

Division of Vital

LINDA FREILICH 31. Data filed (Month, Day, Year)
MAR 1 8 1997 State Registrar

29b. Signature and title of certifier

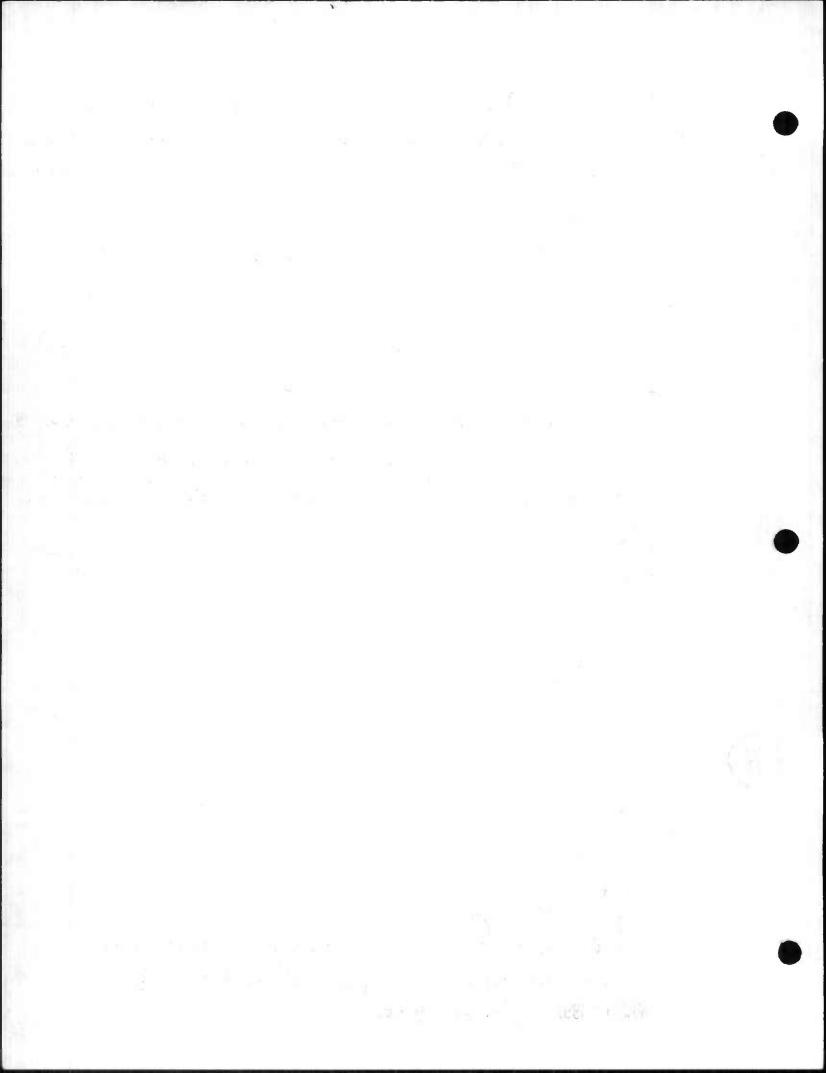
32 Registrar's Signatura Wia Davidson

30. Nama and address of person who completed cause of death (Item 23e) (Type, Print)

(01

29c. Licensa number

29d. Dete signed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

						ertificate of	Death		Reg. No.	37	08127
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	/Medi	cal	MICHAEL JOSEP	11	KAHL		41 O't T	March		997	10:15 A.N
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-	_	_	STELLA MARIS HO 5. Social Security Number 6.5		yrs. lest birthd	ev) If Undar 1 Yaa	TOWSON r If Under 24 Hrs.	R Date of Bir	BALT	IMOF	RE Gototo on Foreign
	Funeral Director		217-26-7510 Usuel Residence of Decedent	67 67 67	Yrs. Yrs	Months Dev		(Month, De	28,1929		plece (Steta or Foreign intry) aryland
	Pue Ma		10a. Stete 10b. County	100	c. City, Town o	r Location				Т	10d. Inside City Limits
	he Mary	ector	Maryland Balti	more	Ba	ltimore C	ounty				1 □ Yas 2√□(No
	ath with the 23s or 2	Funeral Director	8101 Smith Drive	,		10f. Zlp Code	21222		10g. Citizen of V		intry?
21215-0020	n 72 hours after death with the Maryland "natural", or frems 23a or 28a-f show tidical Examiner must be notined at	by	11. Merital Stetus 1 ☐ Never Merried 2 ☐ Merried 3 Widowed 4 ☐ Divorced	12. Wes Decedent Evar Armed Forcas? 1 ☑ Yas 2 ☐ No If Yes, Give ☑ OTE	in u,s.	3. Wes Decedent of If Yas, specify Cu 1 ☐ Yes 2 ☑ No	Hispanic Origin? (S. ban, Mexican, Puarto Specify:	pecify Yes or No o Rican, etc.)	Specify	ck, White	ican Indien, , etc. îte
5-0	72 h netu	Completed	15. Decedent's E (Specify only highest gro	ducation ada complated)	16a. De	cedant's Usuel Occi	upetion a during most of wor ed)	king	16b. Kind of Bu	usinass/ir	ndustry
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			Mrs. Janet A. Mil				et and Number or Ru igh Court				
Dre	of He of He r ofth		20a. Method of Disposition	20	b. Plece of Di	sposition (Neme of crametory or other pl	ace)	Deta	20c. Location -	City or T	own, Stete
Baltimore,	permit. Peges 1 and Department of Heelth Important: If Itam 27 any Injury or other to		1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Special	y)	St. Jo	seph Chur	ch CEm. 3-		Fuller	ton,	Maryland
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	Examiner	Examiner	rasulting in deeth)	Dua	to (or as a con	sequance of):	30, ,000			1	unknown
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68760,			Sequentielly list conditions, if any, leading to immadilete cause. Enter Underlying Cause (Diseese or Injury that initiated evants resulting in deeth) Last	collaina	to (or as a con		re cem	pura	Works		Weeks
Box 6	5 D 6	in/Medical	Ĺ								
	the ett	Physician/N	Pert II. Other eignificant conditions of	ontributing to death but not	resulting in th	e undertying ceuse g	iven In Part I.	23b. Dld	tobacco use cor	ntribute 1	to the cause of death?
P.O.	es that the de igned by the e be detached t			1 Yes 2 No 3 Probably 4 Unknown							
Vital Records,	requires that the death cer seen signed by the ettendin should be detached for use	ted by						24e. Wes	an autopsy	24b. W	Vera sutopsy findings vallable prior to
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Z.	DI	Cór						10	Yes 2 No	1	☐ Yas 2☐ No
£	STE	Be	25. Was cesa raferred to medical examinar?	11			26. Plece of Dee	th (Check only	ona)		
5	Physical distribution	၉	1 Ves 20 No		2 ER/Outpa	tient 3LI DOA		oma 5□ Rasi	dence 6 XIOth	er (Speci	HOSPICE
ion	D 0 2	ation:	27. Manner of Deeth 1 Neturel 5 Panding 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time Injur	y W	ury et ork? ⊒ Yes 2 □ No	28d. Describe	how injury occurr	red	
Division	or Attending after death. Director: After death.	Certification:	3 Suicide 6 Could not be datarmined	28e. Place of Injury - a building, atc. (Sp.	At homa, ferm,	street, fectory, office	•	28f. Location (City or To	Street end Numb wn, Stata)	er or Rur	ral Route Number,
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: All completely filled in by the fu	Medical C	29e. Cartifier (Check only one) Certifying Ph	ysician: To the best of my liner: On the basis of exen and mennar stated.	knowledga, da ninetion end/or	eath occurred at tha to investigation, in my	ima, data and plece opinion, daath occur	, and dua to tha rred at the time,	causa(s) and ma dete end place,	inner as a	stated. to the ceuse(s)
	To the within 2 To the comple	Me	29b. Signature and time of confluer	10 003			nya number		29d. Dete signed	d (Month,	
	CX								-		
	6.		30. Name and address of person who				BOLION :	01007			
	Ch	10	DR. EDDIE NAKHUDA 31. Date filed (Month, Dey, Year)	2300 DULAN 32. Registrar's S		LEY KD. '.	rowson, mi	21204			
	Sta Registr			Jula Saine	1.0	600					
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State of Maryland / Department of Health and Mental Hygiene 08128 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Deta of Deeth Month **Physician** March 17, Rosemarie (NMN) Kuhlman 1997 3:05 A.M. /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Manor Care - Medbridge Towson 5. Social Security Number If Undar 1 Yaar If Under 24 Hrs. Birthplaca (State or Foreign Country) 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Dey, **Funeral** 1 □ M 2 🕅 F Deys Hours YES Director Dec. 63 1933 Maryland 212-30-7820 Usual Residence of Decedant 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumetic event, the Medical Examiner must be notified at 1 ☐ Yas 2 XNo Maryland Baltimore County Director Baltimore 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? ò 238 5128 McFaul Road 21206 U.S.A. Funeral Herns 12. Wes Decedent Evar in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Rece - American Indian, Black, White, atc. Peges 1 and 2 should be filed within 72 hours effer on ent of Heelth end Mental Hygiene. Int: If item 27 is marked other than "natural", or item 1 ☐ Yes 2 No If Yes, Give Yaar or Dates: 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 No by Specify: White 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th Grade Manager Retail Sales 17. Father's Neme (First, Middla, Last) 18. Mothar's Nema (First, Middle, Malden Sumema) Be Casimir Mary Joseph Pelczynski Martha Helinski 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Casper Pelczynski/Brother 13109 Pennerview Lane, Fairfax, Virginia 22033 other 20b. Plece of Disposition (Neme of cometery, crematory or other place) 3/19/97 20e. Method of Disposition 20c. Location - City or Town, State permit. Peges Department of Important: If it any injury or confice. 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Ramovel from Stete Gardens of Faith Cemetery Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licensee 22. Neme end Addrass of Facility John C. Miller, Inc. homas 6415 Belair Road, Baltimore, Maryland 21206 uanita 23a. Perti. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock or heer feilure. List only one ceuse on each list. Metastat **Physician** Pancreatie Cancer Immediate Cause (Final disease or condition resulting in death) /Medical **Examiner** Due to (or es e consequence of): Physician/Medical Examiner physician and the bunel-transit Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequence of): thel initieted events resulting in daeth) Last Dua to (or as a consequence of) 950 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 23b. Did tobacco use contribute to the cause of death? ed by 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24a. Wes an autopsy 24b. Were eutopsy findings evallable prior to completion of ceuse of death? performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes ≥ No Other: Nursing Home 5 Residence 6 Other (Specify) 2 this funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) Certification: 28d. Describe how injury occurred After 1 Naturel 5 Pending Investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Routa Number, City or Town, Steta) 2 4 Homicide 24 hours a 29a. Certifier Trifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as steled.

Medical Examiner: On the basis of axaminetion end/or invastigetion, in my opinion, deeth occurred et the time, data and pleca, and due to the ceuse(s) within 24 hor To the Fune completely fi one) end manner stated 29b. Signatu and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) annu

euse of deeth (Mem 23e) (Type, Print)

32 Registrar's Signetur

a Davidson

MD.

3100 St. Paul St, Suite 5.

State Registrar 30. Neme and address of person w

31. Dete filed (Month, Dey, Year) MAR 18 1997

Year)

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death with the Maryland

Baltimore, Maryland 21215-0020

thet the death certificete be executed

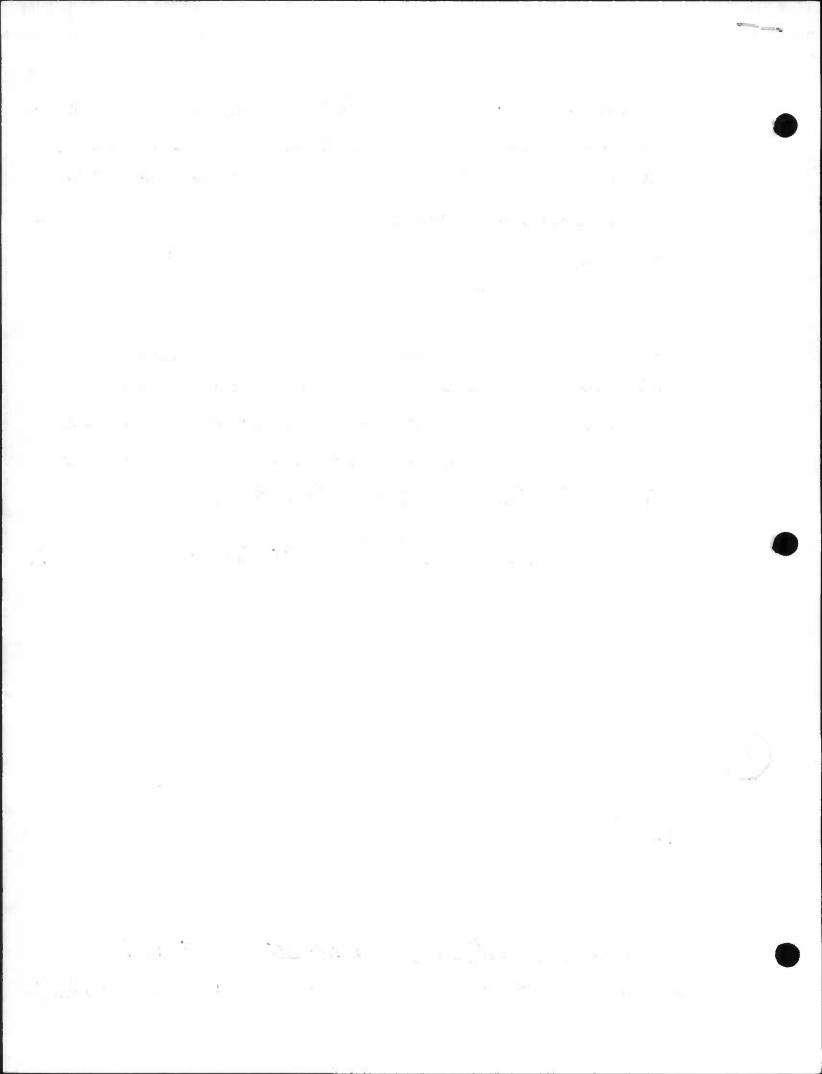
Box 68760.

P.O.

Records,

Division of Vital

or Attending



State of Maryland / Department of Health and Mental Hygiene

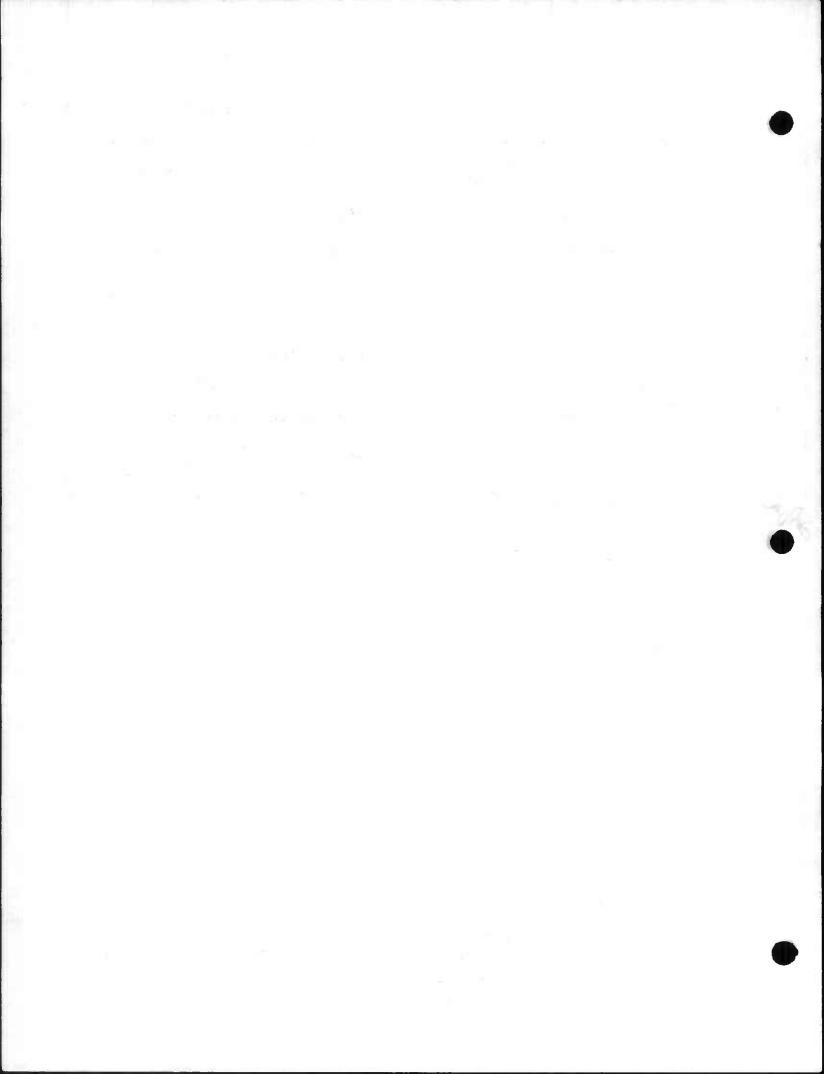
Item 20c Per FH Film G745 3-18-97 rja Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Deeth Day 1997 **Physician** Month STEPHEN S. LUERS MARCH 16 8:20 AM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 1101 D. LONG ROAD APT. D CATONSVILLE BALTO. CO. If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Days Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthpleca (Stata or Foreign Country) **Funeral** 100 M 2□ F Yrs. Director 214-18-0369 86 FEB. 18 1911 Maryland Usual Rasidanca of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Md. n/a 1 □ Yas 2 □ No Director Baltimore 10e. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? 205 E. Cross Street 21230 USA Funeral 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☐ Yes 232 No If Yes, Giva Yeer or Dates; Was Decedant of Hispenic Origin? (Specify Yes or No-if Yas, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, Whita, etc. 11. Meritel Status 1 ☐ Navar Merried 2 ☑ Married 1 ☐ Yas 2 ☐ No Specify: SpecifyWhite by 3 ☐ Widowed 4 ☐ Divorced altimore, Maryland 21215-0 Completed 15. Decedant's Education (Specify only highast grade completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygien Important. If Item 27 is marked other the any injury or other traumatic. 0 Sanitary Worker Baltimore City 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maldan Sumama) Be Henry Luers Ellen Himler 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Grace M. Luers (Wife) 205 E. Cross Street Baltimore, Md. 21230 20b. Plece of Disposition (Name of cematary, crematory or other plece) 20a. Mathod of Disposition Data 20c Location - City or Town, State 1 □ Burial 2 □ Cramation 3 □ Ramoval from Stata March Meadowridge Mem. Parkly 1997 Flkrige, 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Fugeral Service Licensee 22. Neme end Address of Facility McCully Funeral Home of South Balto. 130 E. Fort Ave. Baltimore, Md. 21230 anu 23a. Part1. Entar tha diseasa, or complications that causad the daath. Do not entar tha moda of dying, such as cardiac or respiretory arrast, shock, or haart failura. List only one cause on each line. Approximete interval Between Onsat and Death **Physician** CARCINOMA LUNG /Medical YEAR Immediata Causa (Final disease or condition rasulting in daath) Examiner Examiner physician end s the buriel-transit The law requires that the deeth certificate be executed Sequantially list conditions, if eny, leeding to immadiata cause. Entar Undarlying Cause (Disease or Injury that initiated evants resulting in daath) Lest Dua to (or as a consequence of): Records. P.O. Box 68760. Physician/Medical Dua to (or as a consequance of): Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 5 8 24b. Wara autopsy findings available prior to completion of causa of death? Completed 24a. Wes an autopsy performed? page 2 1 □ Yes 20 No 1 Yes 2 No Division of Vital lal or Attending Physician: The state death.

It Director: After this certificate of in by the funeral director, pt 25. Wes casa rafarrad to medical axaminar? Be 26. Piaca of Death (Check only ona) Hospitel: Other: 4 Nursing Home 5 Residence 6 KROUP HOME 1 ☐ Yas 2 ☑ No Certification: To 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Dascribe how injury occurred 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Natural 5 Panding Invastigation 1 Yas 2 No 2 Accidant 3 Sulcida 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) filled in by 4 Homleida To the Hospital or within 24 hours aft To the Funeral Di complately filled in Medical (1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifian 29b. Signeture end title of certifiar 29c. Licanse number 29d. Data signed (Month, Day, Year) 019640 30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print) S. Honover St. Balto. 21230 S. Posner 1147 m. D 31. Data filed (Month, Day, Year)

MAR 1 8 1997 State Registrar

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Item	n:	26 per Physician			-	artment <i>rtificate</i>			Mental Hy	giene Reg. No.	97 (08130
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Funeral Director		5. Social Security Number 6. S 216-24-3606 Usual Residence of Decedent	©XM 2□F	7. Age (In yrs	s. lest birthday) Yrs.		Deys	If Under 24 Hr. Hours Min			9. Birthplei Country V	ce (Stete or Forei y) A
Man Man	-	10e. Stete 10b. County		10c. C	ity, Town or Lo	ocation			-		100	f. inside City Limit
h the Marylen r 28a-f show	ō	MD N/A				BALT	ГО					XXYes 2□N
or 28a e noti	2	10e. Street end Number				10f. Zip (Code			10g. Citizen of \	Whet Country	13
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d 21215-0020 filed within 72 hours after deeth with the Maryland thygiene. ther than "naturel", or thems 23s or 28s-4 show ont, the Macasal Examine must be notified at	by Funeral Director	11. Merifel Stefus 1 ☐ Never Merried 2 ② Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Deca Armed For 1 Tes If Yes, Giv Yeer or Da	ces? 2]() No e		Wes Decede if Yes, specif 1 ☐ Yes 2		ispanic Origin? (: in, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	14. Rec Blee	ea - American ck, White, etc y: BLA	c.
21215-0020 d within 72 hours af giene. r than "naturel", or the Medical Exam	Completed	15. Decedent's Ed (Specify only highest gra	ducation	ites:	(Give	dent's Usuel kind of work	done d	during most of wo	orking	16b. Kind of Br	usiness/Indu	stry
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Mand 2		19a. informent's Neme/Reletionship (MILDRFD LOMAX	Type, Print)					nd Number or R TERD	BALTO,		Ste te, Zip C 1206	ode)
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Physician /Medical Examiner		shock, or heert feilure. List only immediete Ceuse (Finel disease or condition resulting in death)	e		my o c	quenca or):	1	<i>i</i> h	Farction	on	0	itervei Between Insef and Death
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State		31. Dete filed (Month, Dey, Year)	12 Ao	gistrar's Sign	Shark se		VIC	-116	LDET 9			



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					,	Cert	ificate o	f Death		Reg. No.	7 0	18131
	Dhunia	ian	1. Decedent's Name (First, Middle, Las	t)					2. Data of Dea Month	ith Day	Year	3. Time of Death
	Physic /Medi		Nina G.						March	11, Day 1997	7	8:00pm
	Exami		4a. Facility Name (If not institution, give					4b. City, Town, or	Location of Death			
			Cherrywood Nurs					Reisters.			more	
	Funeral Director		217-46-0759	7. Age □ M 2Ø F 9	2 (In yrs. las		If Under 1 Yas Months Day		8. Data of Birth (Month, Day Sept 2:	Year) 1904	9. Birthplace Country Vurgu	ca (State or Foreign
	B #		Usual Residence of Decedent 10a. Stata 10b. County		10c. City.	Town or Loca	ation				104	I. inside City Limits
	laryla sho	ō	MD Baltimo,			gs Mil					100	1 ☐ Yas 2,☐No
	the N	ect	10e. Street and Number	le co.	owen	ys Mice	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					70,0
	with w	ក់					10f. Zip Code			10g. Citizen of W	vhat Country	"
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nd		Be (17. Father's Name (First, Middle, Last)						me (First, Middle,		θ)	
ya Ma		To	John Miller			•		Dora M	. Fleeno	7		
ar			19a. Intormant's Name/Relationship (7	ype, Print)		19b. Mailing	Address (Street	et and Number or R	lural Route Numbe	r, City or Town,	State, Zip C	ode)
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ore	世界 重要		20a. Method of Disposition \$(2)(Burial 2 Cremation 3	Domousi from State	20b. Plac	ca ot Disposi netery, crema	tion (Name of story or other p	(ace)	Date	20c. Location -	City or Town	n, State
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Baltimore,	permit. Page Department of Important: If any Injury or attos.		21. Signiflum of Funeral Sarvice Licens	iaa /								
œ	88168	4 Donation 5 Dothar (Specify) Clynmaliza Cem. 3-14-97 Monkton, 21. Signature of Funeral Service Licensae 22. Nama and Address of Facility 11824 Reisterstow Eline Funeral Home Reisterstown, MD 23a. Part. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, hook, or heart tailure. List only one cause on each line.										
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≱	4 0 F	Certification:	4 Homicide determined	28a. Place of Inju building, etc.	ry - At home (Specify)	e, farm, stree	t, factory, office	9	28f. Location (S City or Tow	treet and Numbern, State)	er or Rural F	Routa Number,
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			31. Date (ijed.(Month, Day, Year)	la Doubles	170	- Ma	- 24	Klin	4m 400 m	- ')	- 11	2/
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth Month JAMES LITTLE 12. MARCH 199 0400 4a. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth St. Agnes Hospital Baltimore City N/A 8. Date of Birth (Month, Dey, Yeer) Fo.b., 16, 1911 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthpiece (State or Foreign Country) 7. Age (In yrs. last birthday) 101M 20 F Deys Hours Yrs Kentucky 86 719-07-5155 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Edgemere 1 ☐ Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Route 10 Box 641 21219 United States 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2/□(No If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: Specify: 30XWidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementery/Secondary (0-12) College (1-4or 5+) 9 Years Weigher & Scales Steel Industry 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Melvin Little Julia Greene 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 724 North Krocks Road Wescosville. PA 18186 Tommy E. Little/Son 20b. Piace of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removei from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Oak Lawn Cemetery 3/15/1997 Baltimore, Md 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or compilections that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each fine. Approximete Intervai Between Onset end Death Immediate Cause (Final RESPIRATORY FAILURE Due to (or es a consequence of): DAY diseese or condition resulting in deeth) Bilateral Preumonia Week . Chronic OBSTRUCTIVE PULMONARY Disease Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 □Y6s 2 No 3 □ Probably 4 □ Unknown Dementia 24b. Were eutopsy findings eveilebte prior to completion of ceuse of death? 24e. Wes en eutopsy performed?

Physician /Medical Examiner

hat the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Department of Important: If any injury or once.

Physician

/Medical

Examiner

10a State

Funeral

Director

"natural", or items 23a or 28a-f show

should be mon-and Mental Hygiene. Is marked other than "natural"

... Pages 1 and 2 should be filed w tment of Health and Mental Hygiel tant: If item 27 is marked other th jury or other traumatic event, In-

Baltimore, Maryland 21215-0020

Director

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neral Director: After this y filled in by the funeral di Certification:

Physician/Medical Examiner To the Hospital of within 24 hours a To the Funeral D completely filled in Medical

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or Attending Physician:

Sequentielly tist conditions, if any, teeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Pert Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. ALZHEIMERS Prostate CANCER 1 Yes 2 No 1 ☐ Yes 2 No COLON CANCER 25. Wes cese referred to medical exeminer? 28. Piece of Deeth (Check only one) Hospitei: 1 Inpatient 2 □ ER/Outpetient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred 28c. injury et Work? 5 Pending investigation 1 Neturet 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ SuicIde Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 I Homicide 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner stated. 29a. Certifier

29b. Signeture end title of certifier

(Check only one)

MD

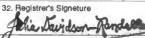
29c. License number P019519 29d. Dete signed (Month, Dey, Yeer)

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

DR. FRANCIS BUADI, ST AGNES HOSPITAL, 900 CATON AVENUE, BALTIMORE, MD, 21229 31. Dete filed (Month, Dey, Yeer)

State Registrar

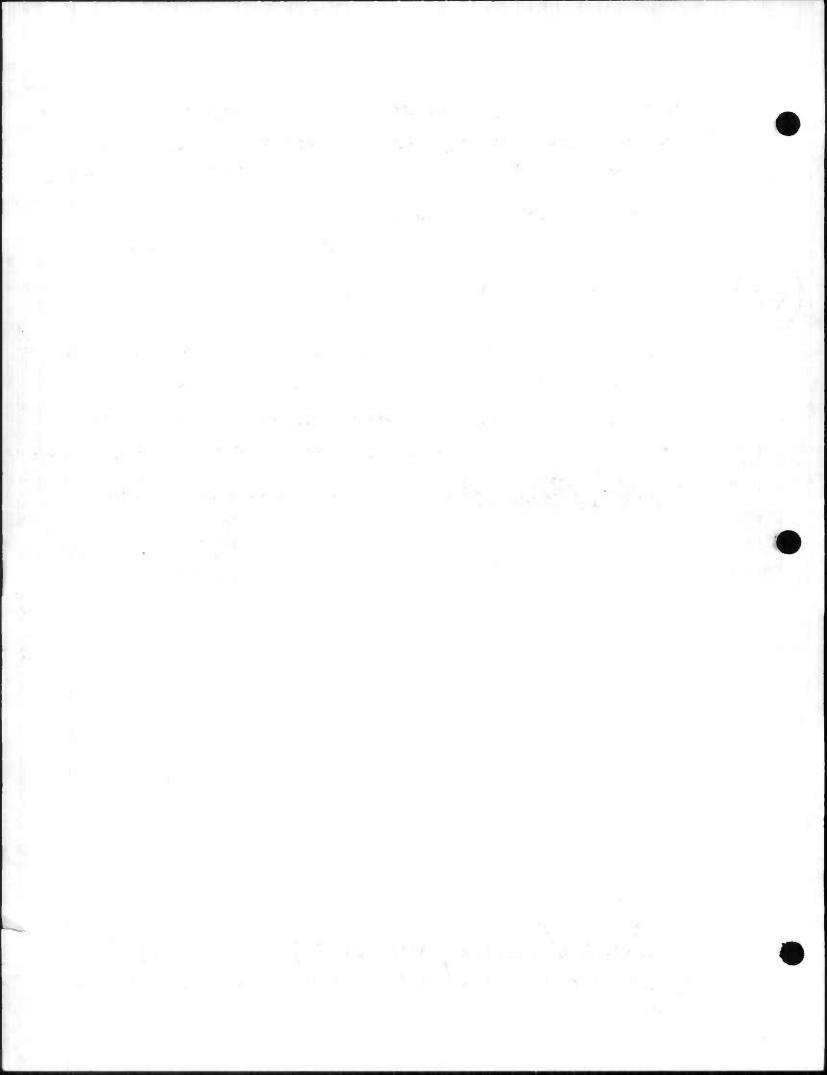
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State of Maryland / Department of Health and Mental Hygiene

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/Medi			L.	MOX	LEY			MARCH			50 AM
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Funeral Director		212-58-7979	. Sax 7. / 1 □ M 2 K F	Aga (In yrs. last b	Yrs. If Uni	nder 1 Year ths Deys		8. Date of Bir	th Year 20,	9. Birthpleca (Si 1958 Vir	tata or Foraign ginia
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icata be executed physician and s the buriel-transit		Sequantially list conditions, if any, laeding to immadiata causa. Entar Undarlying Cause (Disaasa or Injury	C	Lu	ngl	anci	er			lun	known
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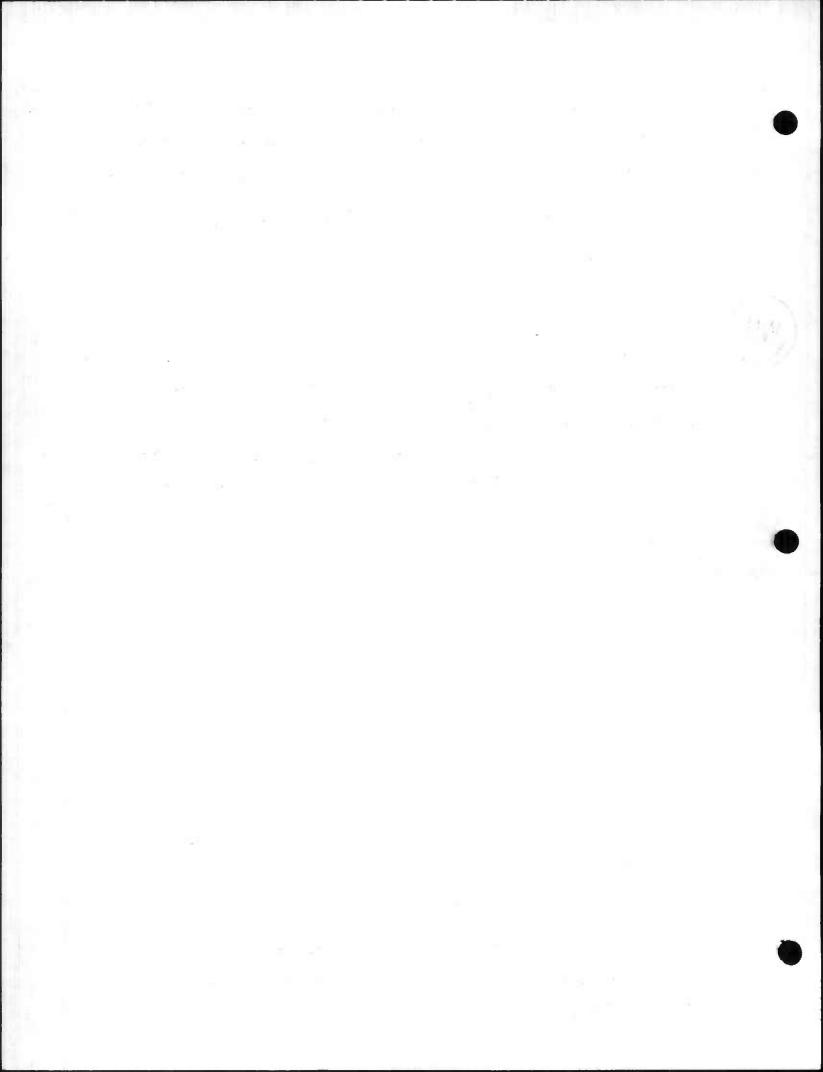


State of Maryland / Department of Health and Mental Hygiene

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10		30. Nama and address of person who	omplated ceusa of d	aath (Itam 23	a) (Type, Prir	it)					
,		RICHARD L. LI	NTHICUM	, M.D.	, 76	20 YOR	K ROAD	TOWSO	N, MD.	21	204
Sta	е	31. Data filed (Month, Day, Yaar)	32. Registr	ar's Signatura	and the same						

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month MATTAX 08:55 pm. MYRTLE MARCH 1997 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death unde 610 AV HOSDITA If Under 1 Yeer | If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 1 M 2 KF Deys Hours 226-28-6669 Yrs. 86 28, 1910 Nov. Virginia Usuei Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel Glen Burnie 1 ☐ Yes 2 X No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 369 Taylor Avenue 21061 U.S.A. 14. Rece - American Indian, Bleck, White, etc. 11. Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2 🔯 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6th Waitress Rice Bowl 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Ruben Cordle Mary E. Cordle 19a. Informant's Neme/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby Carney (Daughter) 1315 South Hanover Street Balto., MD. 21225 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 | Burial 2 | Cremetion 3 | Removel from Stete 4 | Donetlon 5 | Other (Specify) Glen Haven Memorial Park 3/19/97 Glen Burnie, Maryland 21. Signeture of Funerel Service Licensee Ecker McCully Funeral Home of Brooklyn Kevin E. 237 E. Patapsco Ave. Balto., Md. 21225 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were sutopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed?

Physician /Medical **Examiner**

physician and the burial-transit

attending pl

ate has been signed by the a page 2 should be detached

certificate

this funeral

After

To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

director,

Hospital or Attending Physician:

The law requiras that the death certificata be executed

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

à

Completed

Be

2

Certification:

Medical

Baltimore, Maryland 21215-0020

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Pages 1 and 2 should be illed within tent of Health and Mental Hygiens.

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Important: If It any injury or o

Physician

/Medical

Examiner

10e Stete

MD.

Funeral Director

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Completed

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Funeral

Director

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last

1 Yes 2 No

26. Piece of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

27	Menner of	Death	
	1 Yes	2 ☑ No	
20.	examiner		to medical

5 Pending investigetion 2 Accident

6 Could not be

1 Minpatient 28a. Dete of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e, Certifie (Check only one)

11/1

31. Dete filed (Month, Day, Year)

MAR 1 8 1997

1 Neturei

3 Sulcide

4 - Homicide

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner stated.

29b. Signature and title of certifier

51010

29c. License numbe

29d. Date signed (Month, Day, Year)

30, Neme end address of person with pleted cause of deeth (Item 23a) (Type, Print) nammaa

State Registrar

32. Registrer's Signature

3. TIME OF DEATH

8. BIRTNPLACE (State or Foreign Country)

Virginia

4:45 pm

1. DECEDENT'S NAME (First, Middle, Last)

JAIlie

4. SOCIAL SECURITY NUMBER

230-24-3038

V.

9e. FACILITY NAME (If not institution, give street and number)

Mewshaw

8. AGE (In yrs. last birthday)

77

5. SEX

1 M 2 XF

IF UNDER 1 YEAR

IF UNDER 24 HRS.

9b. CITY, TOWN OR LOCATION OF DEATN

2. DATE OF DEATH MONTH

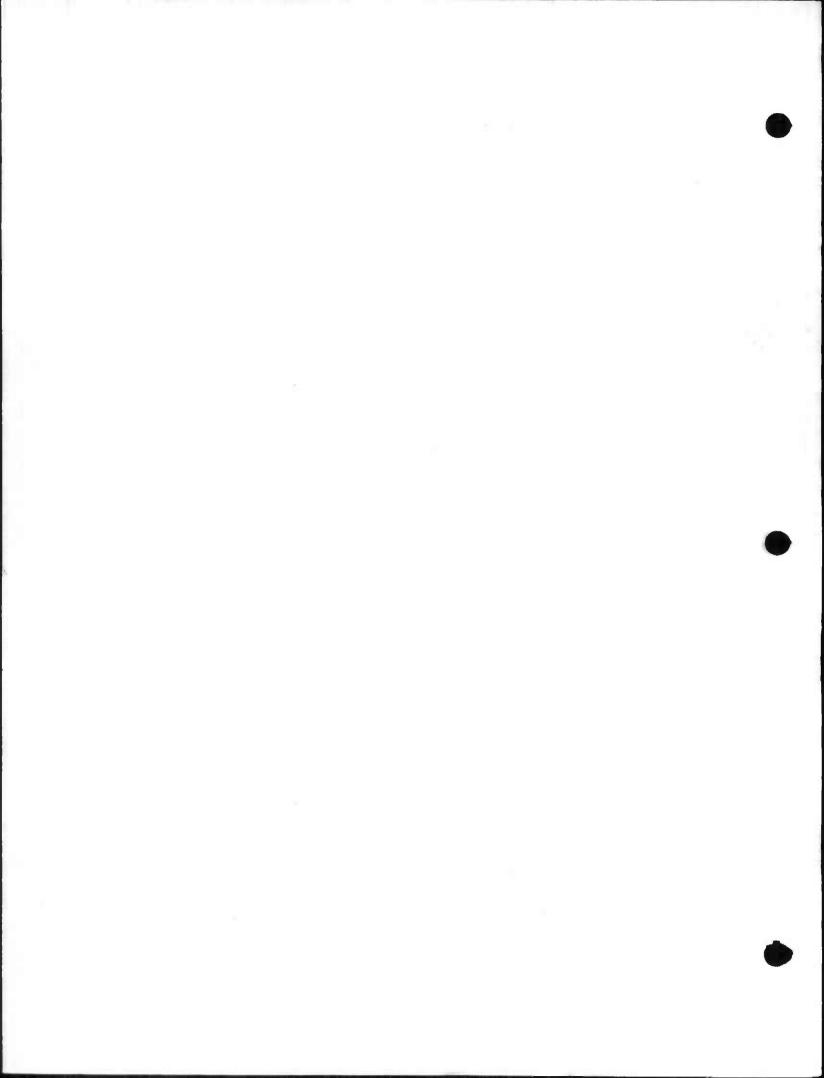
7. DATE OF BIRTH (Month, Day, Year) April 16,1919

DAY

YEAR

9c, COUNTY OF DEATN

ITAL STATUS aver Married 2 Idowed 4 Div 15. DEC (Specify on nentary/Secondary (INKNOWN NER'S NAME (First, A IMCS FORMANT'S NAME (INTICS W ETNOD OF DISPOSITIES 2 W CETNOD OF DISPOSITIES 2 W CETNOD OF DISPOSITIES 2 W CETNOD OF DISPOSITIES (INTICS W ETNOD OF DISPOSITIES 2 W CETNOD OF DISPOSITIES 2 W	10b. COUNTY Baltimo Record 12. WAS Defended 12. WAS Defended 12. WAS Defended 15. WAS Defended 16. WAS DEFENDED	Apt. 2 ECEDENT EVER IN U ES? 1 YES GIVE WAR OR DATE 1-4 or 5+) L SON State Comple Gre ons that caused to one ceuse on eec	S. ARMED 2 XNO SS S S S S S S S S S S S S S S S S S	13. WAS DEC It yes, ap 1 VES. USUAL OCCUPATION OF CONTROL OCCUPATION OCCUPAT	White 2. ZIP CODE 2112: ENDENT OF HISPAN ecity Cuben, Mexice 2 (XNO Specifi DN Specifi 18. MOTHER'S NA Lillia and Number or Rural Spring Ro and Of Specifi Tong Ro and Of Specifi Spring Ro and Of Stephen Green Pa da of dying, suc	INC ORIGIN? (Specify in, Puarto Rican, etc.) 16b. KIND OF E 16b. KIND OF E 16b. KIND OF E 16c. KIND OF E	Unite We or No- 14 We sta White LOCATION - Chp Baltimo ann P.A r., Bal	Workman Workman 21128 Marsh,MD y or Town, Stete re, MD 21286 timore, MD d. Approximata interval Between Onset and Death								
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nitiated events ing in death) LAS ii. <u>Other</u> signific	ent conditiona contribu		ONSEDUENCE OF	F): In the underlyIn	g cause given in	Part I. 24e. WAS PERF	AN AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO								
TOBACCO L	USE CONTRIBUTE 1			S NO TN (Check only one)		N D										
AMINER?	HOSPIT			OTHER:		8 Other (Specify)										
Netural 5 Accident	28a.	DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. IN.	JURY AT ORK? YES 2 NO	28d. DESCRIBE HO	W INJURY OCCUI	RED								
Suicide 8	28e.	PLACE OF INJURY building, atc. (Specify	At home, ferm,	street, fectory, offic	CO	281. LOCATION (Stre City or Town, Str	et and Number or ate)	Rural Route Number,								
29a. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and due to the cause(a) and menner as stated,																
-1	2 MEDICAL EXAMINER: On the beals of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as 296. SIGNATURE AND TITLE OF CERTIFIER 296. SIGNATURE AND TITLE OF CERTIFIER 297. DATE SIGNED (Month, Day, Year)															
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Maryland 21215-002	ural,	d by	3 Widowed Windowed	If Yes, Give 11 Year or Detas	:		Yes 2X No	Specify:		Specify	whi	te
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Ĕ	Page nact c ant: If ury or		1 Surial 2 □ Cremetion 3 4 □ Donetien 5 □ Other (Special Control of the Control		° Cres	tlawn	Mem.G	ardens	March 20 199	7 Marr	iots	ville Md.
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4	/Medical Examiner		Immediate Cause (Final diseasa or condition	5	mall	Bow	el o	bstruc	How			4 Days
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	be executed ician and buriel-transit	Xar	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that kill listed events.		Due to (or as	s e consequar	nce of):					
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	deat death ed for	sicia	Pert II. Other significant conditions	contributing to death	but not resultin	ng in tha under	rlying cause give	en in Pert I.	23b. Did	tobacco use cor	atribute to 1	the cause of death?
P.0	thet the death certifi ed by the attending I detached for use es	Phy	COPD						1□	Yes 2 No	3 Probe	ibly 4 Unknown
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Sign	death death tor: /	Cat	2 ☐ Accident investigati	be as su				Yes 2□No	006 111	· · · · · · · · · · · · · · · · · · ·		
Division	after Direct	ert	4 ☐ Homicide determine	28e. Plece of Ir building, 6	etc. (Specify)	e, rarm, street,	rectory, onice		City or To	Street and Numb wn, Stete)	er or Huraii	Houre Number,
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edicai	(Check only 2 Medical Exp	end menner s	of exeminetion	end/or Investi	igetion, in my or	pinlon, deeth occ	curred et the time,	dete end plece,	end due to t	he cause(s)
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	1λ		30. Name and address of person who			le) (Type, Prin	t)	,			// 1	
	V \		Dick (KNO	UM	m >	2:	2 S. G	reene	Street	Baltim	ore,	Md 21201
	Sta Registra		31. Dete filed (Month, Dey, Year) MAR 1 8 1997	Regis	trar's Signeture	fandelle.						

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** PORIS MANVILLE March 16 1997 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard County 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

75 Yrs. Months Days Hours Min. 5. Social Security Number 042-14-2079 8. Date of Birth 9. Birthplece (State or F 9. Birthplece (State or Foreign **Funeral** 1 M 2 F Director Usual Residence of Decedent 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits Howard County Maryland 1 Yes 2 No Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10612 Graeloch Court 20723-1187 USA 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: à Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w Department of Health and Montal Hygiens Important: If Nem 27 is marked other that any Injury or other traumetic — once. homemaker own home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) August Carini Jeanette Gesner 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Ms. Diane Manville/daughter 10612 Graeloch Court, Laurel, Maryland 20723 20e. Method of Disposition 20b. Place of Disposition (Neme of cametery, crematory or other placa) 20c. Location - City or Town, State 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Baltimore Washington Crematory 3-18-97 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryland 22. Name and Address of Facility Slack Funeral Home, P.A. ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death hysician Medical/ KESPIRATORY FAILURE immediate Cause (Fine disease or condition resulting in death) Examiner Examiner physician end s the burief-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, à Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Division of Vital Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Certification: To 1 Yes 20€No funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending s effer death.
I Director: Aff 1 Tyes 2 No 2 Accident Investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

The WENS MD 11 055

31. Date filed (Month, Day, Year)

32. Registrar's Sinnature 29c. License number 29d. Date signed (Month, Day, Year) Little Paturent State a Taridson-Randell MAR 1 8 1997 Registrar

Call of Man State Bills . In

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 1^{Day}, Month 1997 Margaret В. Miller March 12:35 AM 4b. City, Town, or Location of Deeth 4a. Facility Nema (If not Institution, giva street and number) 4c. County of Death 322 Murdock Road Baltimore | H Under 1 Year | if Under 24 Hrs. | 8. Data of Baltimore 5. Social Security Number 8. Data of Birth (Month, Pay, Year) MAR 10, 1907 6. Sax 7. Aga (In yrs. last birthday) Birthpiace (Stata or Foreign Country) Days 1□ M 2√2 F 215-40-4797 90 Yrs. Maryland Usual Rasidance of Dacedant 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Baltimore 1 ☐ Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 205 Regester Avenue 21212 USA 12. Wes Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yes, Give Yaer or Datas: 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - American Indien, Bleck, White, etc. 1 Nevar Married 2 Married 1 ☐ Yas 2 🖾 No Specify: Specify: White 3 XWidowad 4 Divorced 15. Decadant's Education (Specify only highast grade complated) 16a, Decedant's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) Elemantary/Secondary (0-12) College (1-4or 5+) Substitute Teacher Public School 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) George W. Buchman Lettie Perkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code) C. Carroll Miller, Jr./son 322 Murdock Rd. Baltimore, MD 21212 20b. Pleca of Disposition (Nama of cematary, cramatory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 ☐ Burial 2X Cramation 3 ☐ Ramoval from Stata Metro Crematory, Inc. 3/17/97 4 Donetion 5 Other (Specify) Baltimore, MD 22. Nama and Addrass of Facility Cremation Society of Maryland, Inc. 21. Signature of Funeral Sarvice Licenson George E. MacNabb 299 Frederick Rd. Baltimore, MD 21228 23e. Pert1. Entar tha disaase, or complications that caused tha death. Do not enter tha mode of dying, such as cardiac or respiratory arrast, shock, or haart failure. List only ona cause on each line. Approximete fnterval Batween Onsat end Death Immediata Cause (Final Cohmonan I moned als diseasa or condition resulting in death) 2 weeks Mitable lug CA Dua to (or as a consequanca of): LUNG CHUCEK Dua to (or es e consequança of): 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 donknown 1 Yes 2 No 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed?

Physician /Medical **Examiner**

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attanding physician for use es the buna

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After this Phy

completely filled in by the To the Hospital or Attenwithin 24 hours after deat To the Funeral Director:

that the death certificate be executed

Records, P.O. Box 68760

Vrtal

Division of

Attending

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Examiner

Physician/Medical

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Completed

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Certification:

Medical

Physician

/Medical

Examiner

10a. Steta

Director

Funeral

by

Completed

MD

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours after death with the Manyland Depertment of Health and Mantal Hygiane.
Important: If them 27 is marked other than "neturel", or items 23s or 28s-f show any injury or other traumatic event, I'm Modical Exertment the notified at

Baltimore, Maryland 21215-0020

Sequantially list conditions, if any, leading to Immadiata cause. Entar Underlying Causa (Disaasa or injury that initiated avents rasulting in daath) Last

Part If. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i.

completion of causa of daath?

1 ☐ Yas 2 ☐ No

1 Yas 2 No 25. Wes casa refarred to medical 26. Place of Death (Check only one)

exeminar? Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Pasidanca 6 Other (Specify) 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred

27. Manger of Death 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicida 281. Location (Street and Number or Rural Routa Number, City or Town, Stata)

 Piaca of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 4 ☐ Homicida

M.D.

Baltimore, MD 21211

1 🗹 Certifying Physician: To tha best of my knowledge, deeth occurrad at tha tima, data and placa, and dua to tha causa(s) and manner as steted. 29e. Certifian (Check only one) 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of cartifiar 29c. Licansa number 29d. Date signed (Month, Day, Year)

3825 Greenspring Avenue

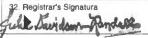
30. Name end addrass of person who complated causa of daath (Item 23e) (Type, Print)

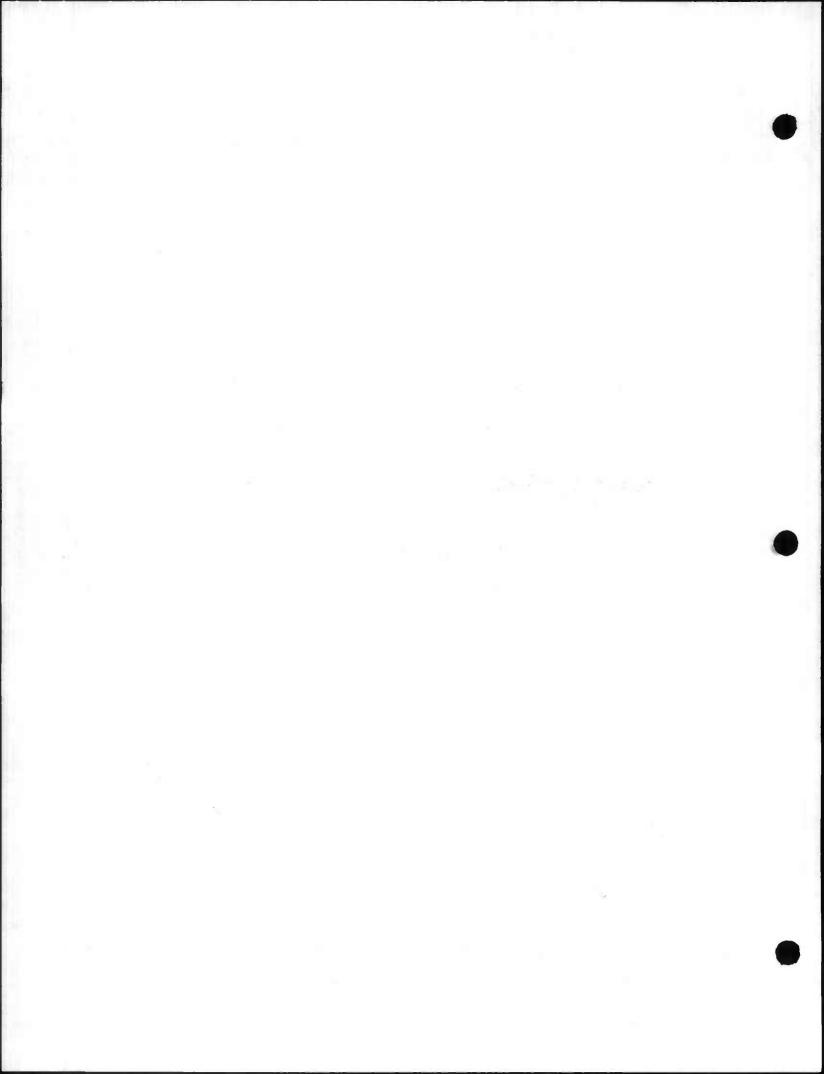
D-01782 March 17, 1997

State Registrar

31. Data filed (Month, Day, Year) MAR 18 1997

Lee E. Gresser,





Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dey Mary Ruth Myers 9, 1997 March 7:00 AM 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 425 South Eden St. Baltimore 5. Sociel Security Number if Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. iast birthday) Birthplece (State or Foreign Country) Deys 1□M 2♥F Yrs 86 236-14-6295 July12,1910 W. Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Md. Baltimore 1X Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 425 South Eden St. 21231 USA Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American indien, Bleck. White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes ② No If Yes, Give Year or Detes: 1 Yes 2 No Specify: Specify: White 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 5 yrs. Housewife Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ines Bud Helmick R.C. Fawley 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Hardy 425 South Eden St. Baltimore Md. 21231 20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Dete Burial 2 Cremation 3 Removel from State Mt. Zion Cem. 3 - 13W. Virginia 4 ☐ Donetion 5 ☐ Other (Specify) re of Funeral Service License 22. Name end Address of Facility Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) Congestive He Due to (or es e consequence of Heart Failure Due to (or es a consequence of): Severe Mitral Requiretation Failure and Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Wes en eutopsy performed?

Physician /Medical Examiner

that the deeth certificate be exacuted

d peud

To the Hospital or Attending Physician within 24 hours efter death.

To the Funeral Director: After the completely filled in by the funeral director.

Be Completed

Medical Certification: To

P.O. Box 68760,

Division of Vital

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

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10a State

Funeral

Director

the Maryland

permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hyslene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-1 show this injury or other treumatic event, the Medical Examiner must be mattered and

Baltimore, Maryland 21215-0020

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Physician/Medical by

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

High Blood Pressure

24b. Were eutopsy findings eveilebie prior to completion of cause of death?

1 Yes 2X No 26. Plece of Deeth (Check only one)

1 TYes 2 No

25. Wes case referred to medical exeminer? 1 Yes 2X No 27. Menner of Deeth

1 Neturel

2 Accident 3 Sulcide

4 Homicide

5 Pending investigation

6 Could not be determined

28e. Dete of injury (Month, Day Year)

1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury et Work? 1 Tyes 2 No

Other: 4 Nursing Home 5 NResidence 6 Other (Specify) 28d. Describe how injury occurred

 Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pieca, and due to the cause(s) end manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, dete end piece, and due to the cause(s) end menner steted. 29e. Certifier

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signeture and little of gertifier

29c. License number

30. Name end edd

ess of person who completed cause of deeth (Item 23a) (Type, Print)

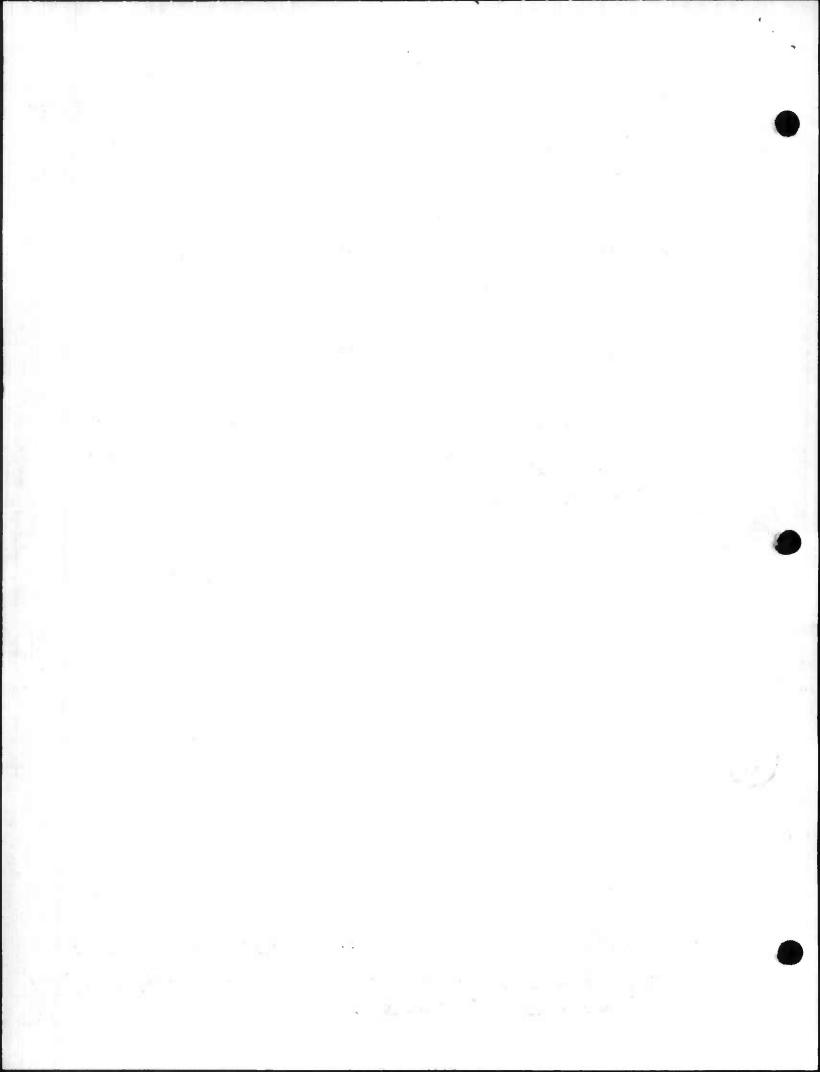
Foster Ave Balt MD21224

31. Dete filed (Month, Day, Year)

32. Registrar's Signature

ia Davidson MAR18 199

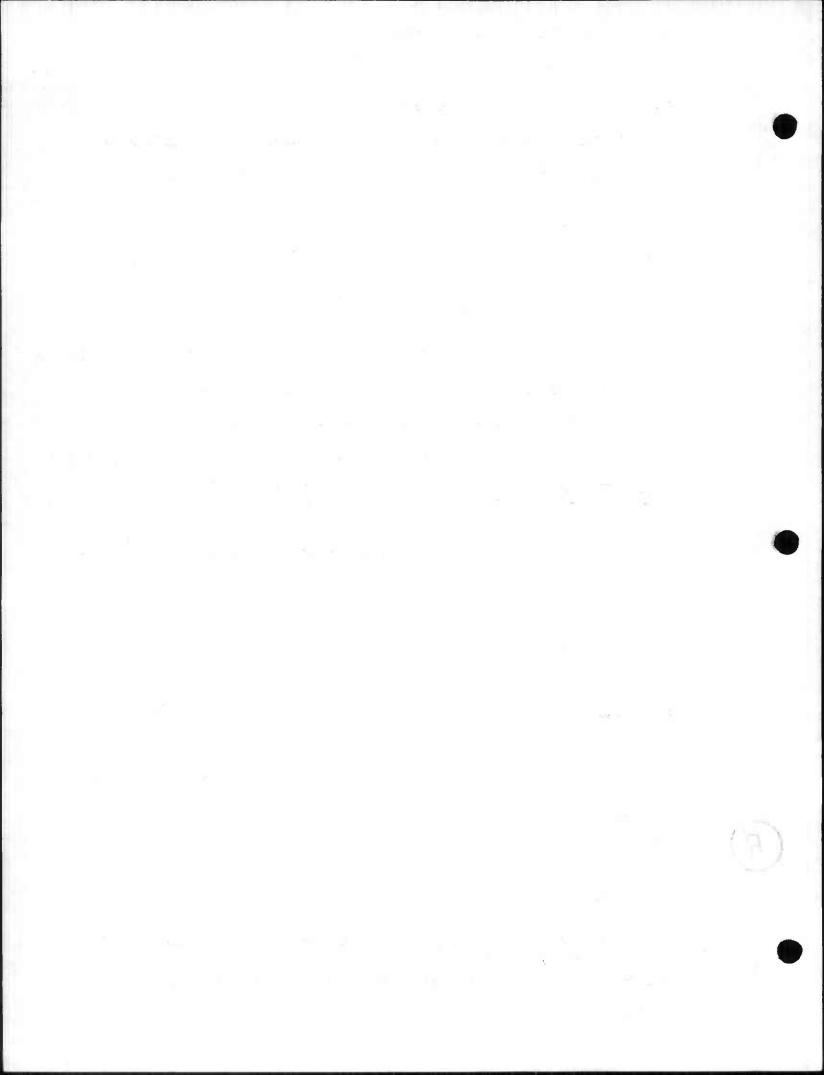
State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1997^{Year} March 12, **Physician** Robert MARCONI 2:52 am /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Center Rosedale Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
PA. **Funeral** Days 1 M 2 □ F May 10, Director 201-26-4306 59 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or frame 23s or 28s-f shot traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4428 Wynn Road 21236 permit. Peges 1 end 2 should be filed within 72 hours efter death v. Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a and Injury or other traumatic event, the Medical Examinat mast ence. U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑XYSS 2 ☐ No If Yes, Give Year or Dales: 1958–1962 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No by Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanical Electrical Contr. Safety Inspector 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) 2 Leno Joseph Marconi Mary Ozohonish 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) Robert Marconi, Jr. (Son) Kingsville, Md. 21087 2811 Jerusalem Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Ramoval from State Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 3/13/97 Baltimore, Maryland 21. Signature of Funeral Service Upenson 22. Name and Address of Facility E. F. Lassahn Funeral Home assakx 11750 Belair Road Kingsville, Maryland 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Aortic Dissection with Cardiac Tamponade 8 Hours Examiner Dua to (or as a consequence of) Examiner physician end the buriei-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disaasa or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): Box 68760. certificate be Physician/Medical Due to (or as a consequence of): 88 ettending esn o signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, P.O. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertension by should should Completed 24e. Was an autopsy 24b. Were autopsy findings aveileble prior to completion of cause of death? has certificete 1 Yes 2 □ No 1 Yes 2 No director, 25. Was case referred to medical examinar? Be 26. Place of Death (Chack only one) Hospital: To 1 Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of Certification: 28c. injury at Work? 28d. Describe how Injury occurred 1 Naturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of fnjury - At home, farm, straet, factory, office building, etc. (Specify) 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical pletely (Check only one) To the I within 2 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D27315 March 12, 1997 mplatad cause of death (Itam 3a) (Type, Print) 9000 Franklin Square Drive, Baltimore, Maryland M L Frydenborg M.D. 31. Data filed (Month, Day, Year) 32. Registrer's Sharture State MAR 18 1997 Registrar



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of Maryla		tificate of			giene Reg. No.	97 1	08142	
	Physici /Medi		1. Decedent's Neme (First, Middle, Last Mary E .]	Nodonly				2. Date of Dee Month March	Day 12,1997	Year	3. Time of Death 9:38 am	
	Examir		4a. Facility Name (If not institution, give Johns Hopkins Bay 5. Social Security Number 6. Se	street end number) yview Medical	Center		4b. City, Town, or L Baltimor If Under 24 Hrs.	ocation of Deeth	4c. County			
	Funeral Director		216-16-1115 Usual Residence of Decedent	² M ² M ^F 73	Yrs.	Months Deys	Hours Min.	8. Dete of Birth (Month, Dey Nov. 21			ce (Stete or Foreign y) land	
	Merylen a-f show	tor	Md. Baltir		City, Town or Loc Dundalk					100	d. Inside City Limits 1 ☐ Yes 2X No	
	th with the 23a or 28	Funeral Director	10e. Street and Number 4233 Lynhurst I	Rd.		10f. Zip Code 21	222	1	10g. Citizen of N	What Countr	y?	
020	urs after dea al', or items	by	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes Y No If Yes, Give Year or Dates:		Vas Decedent of I Yes, specify Cub ☐ Yes 2 No	Hispanic Orlgin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		e - American ck, White, et White	Ic.	
21215-0020	s 1 and 2 should be filed within 72 hours after death with the Menylend if Heelth and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, its Medical Example must be notified at	Completed	15. Decedent's Edu (Specify only highest gred Elementary/Secondery (0-12) 12 yrs	cation le completed) College (1-4or 5+)		ent's Usual Occup kind of work done DO NOT use retire	pation during most of work d)	sing	16b. Kind of Bi		stry	
Maryland ;	should be filed with and Mental Hygiene. s marked other than aumetic event, the M	To Be C	17. Father's Name (First, Middle, Last) Richard Debes		1		18. Mother's Nam Antoni	e (First, Middle, a Zach		ne)		
Man	d 2 sho th and ? 7 is me traume		19a. Informent's Name/Relationship (7) Alexander Node				end Number or Rui					
Baltimore,			20a. Method of Disposition 11 Burial 2 □ Cremation 3 □ F 4 □ Donetion 5 □ Other (Specify)	20b. Removal from Stete		sition (Neme of netory or other ple	urst Rd.		20c. Location -	City or Tow		
Balti	permit. Pege Department of Important: If any Injury or once.		21. Signature of Funeral Service Licens		22. Name and Address of Facility Connelly Funeral Home Of Dund 7110 Sollers Point Rd. 21222 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interest,							
	Physician /Medical		23a. Part : Enter the disease, or complishock, or heart failure. List only of Immediate Ceuse (Final	licetions that caused the de- ne ceuse on each line.	ath. Do not ente	er the mode of dyla	ng, such as cardiac	or respiratory arr	rest,	1 1	Approximete ntervai Between Onset end Death	
	Examiner	ner	disease or condition resulting In death)	Cotone	(or as a consequence	uenca bf):	alsea?	do.			10 yours	
,00	ficete be executed g physician and es the bunel-transit	I Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that bit interest that the county of the county	b	(or as a consequ	uence of):	٠,٠٥٥	3		1	, / 4 3	
ox 68760,	T 00 0	//Medical	resulting in death) Last	Due to	(or as e consequ	uence of):						
P.O. Box	the deatl y the ette sched for	Physician/M	Part II. Other eignificant conditions con	ntributing to death but not re	esulting In the un	derlying cause gi	ven in Part I.		obacco use co 'es 2 No	ntribute to t	he cause of death?	
Records,	been signishould be	by	- Ch(enc	1 Anat	oll . Mac			24a. Was a	an autopsy med?	aveil	e autopsy findings leble prior to pletton of cause	
	The law ate hes pege 2	Completed						1 □ Y	es 2 No	of de	Yes 20 No	
Vita	sician: cariffo iractor,	o Be	25. Was case referred to medical examiner?	Hospital:	M	Ott	26. Place of Deal					
sion of	Da luneral d	-	27. Menner of Deeth 1 Notural 2 Accident 5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	4 Li Nuising He	ome 5 Resid				
Div	ital or the urs after ral Directi	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined	28e. Piaca of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office		28f. Location (S City or Tow	treet end Numb n, State)	er or Rural I	Poute Number,	
	To the Hospital within 24 hours To the Funeral completely filled	edical	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	eiclan: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, death nation and/or Inv	occurred at the tile estigetion, in my o	me, date and plece, pinion, death occur	end due to the c red et the time, d	ause(s) and ma lete end piace,	inner as stat and due to t	ed. he cause(s)	
	To the within 2 To the comple	W	29b. Signature and title of certifier	rul.	M	29c. Licens	se number		9d. Date signe			
	8		30. Name end address of person who co					4940 E	astern	Avenue	2	
	Sta Registr	7	Gary Briefel, MD 3 31. Date filed (Month, Day, Year) MAR181	32. Registrar's Sign	Bayvie Baydson-	w Medica	1 Center	Baltim	ore, MD	2122	!4	

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Death MILDRED Α. ORME 8:30 am MARCH 15. 1997 4e. Fecility Neme (If not Institution, giva straet end number) 4b. City, Town, or Location of Daath 4c. County of Death 12 CEDAR HILL ROAD RANDALLSTOWN BALTIMORE 5. Social Security Number if Under 1 Year if Undar 24 Hrs. Hours Min. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) Months Deys 1 M 2 KF Yrs 216032664 90 FEB 28,1907 MARYLAND Usuel Residence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits NYas 2 No N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 3939 ROLAND AVE 21211 USA 12. Wes Dacadant Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Ricen, atc.) 14. Race - American Indian Bleck, Whita, atc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 ☐ Never Marriad 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ₩ Widowed 4 Divorcad WHITE 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME UNK. UNK. 17. Fether's Neme (First, Middle, Last) 18. Mother's Nema (First, Middle, Meidan Sumeme) CHARLES WESLEY MAIN ELIZABETH DINAMEN 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 35806 6229 RIME VILLAGE DR. HUNTSVILLE , ALABAMA JAY SIMMS/ GRANDSON 20b. Pleca of Disposition (Neme of cemetery, cremetory or othar place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 3/20/97 MORELAND MEMORIAL BALTIMORE, MD 21. Signature of Funeral Service Deensee 22. Name end Address of Fecility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final disaase or condition resulting in deeth) Due to (or es a consequence of) Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of). Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 3© Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were eutopsy findings availabla prior to completion of cause of death? 24a. Wes en eutopsy performed? 2000 1 ☐ Yas 20 No 1 Yes 26. Piece of Deeth (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Neturel 5 Pending Investigation

and De exec Vital Records, P.O. Box 68760, Physician/Medical The law requires that the death certificate glift igned by by Completed sician: 88 2 Certification:

Physician

/Medical

Examiner

Funeral

Director

28a-f show

8 23a Director

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Completed

Be

traumatic event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death tent of Health and Mental Hygiene.
nt: If Item 27 Is marked other than "naturel", or items 23.

Department of Health a Important: If Item 27 Is any injury or other trace once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

with the Maryland

25. Wes case referred to medical exeminer? 1 Yes 2500 27. Megner of Deeth

28e. Dete of Injury (Month, Dey Year)

Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier

Medical

2 Accident 3 Suicide

4 Homicide

Excertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) end mannar stated. 29c. License number

29b. Signetura end titla of certiliar

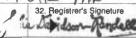
29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

10 TOP IA WANTIV MD 3400 Brehms have Balt MD

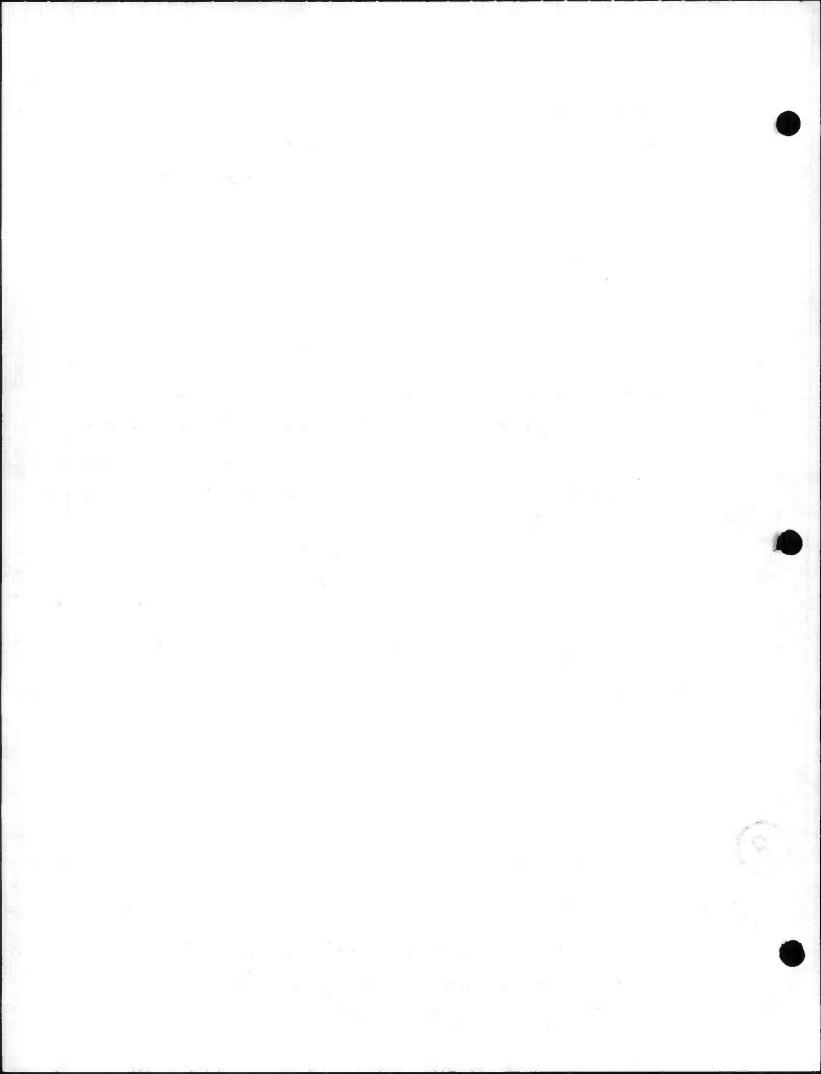
6 Could not be determined

31. Dete filed (Month, Dey, Year) State MAR 1 8 1997 Registrar



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within 2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Oliver 7:30PM Willie 77 1997 5 4a. Facility Name (If not institution, give straat and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Ruther ford War Dayton Howare If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Country) 8. Deta of Birth (Month, Day, Year) 10 M 20 F Months Yrs. 213-62-7561 0-15-1955 Usual Rasidanca of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Md Howara 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? . S.A 4507 21036 Way 12. Was Decadant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 11. Maritai Status 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yas 2 1 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 ☐ Yas 2 No Specify. 3 ☐ Widowed 4 ☐ Divorcad Slack 15. Decedant's Education (Specify only highast grada complated) 16a. Decadant's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work dona during most of working lifa. DO NOT usa ratired) Occounting Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12th grade + College 1ax Attorney 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) William James Tarjorie Hughes wer 19a Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar of Rural Routa Number, City or Town, Stata, Zip Coda) Hamela Rutherford Way Dayton, Md 2 20c. Location - City or Town, Stata 0 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Data 1 Burial 2 □ Cramation 3 □ Removel from State 4 □ Donation 5 □ Othar (Specify) Baltmore, Centery. 3-19-97 21. Signature of Funarai Servica Licansas 22, Nama and Addrass of Facility/ H. West 23a. Part1. Enter tha disaasa, or comblications that causad tha daath. Do not antar tha mode of dying, such es cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Balto, nd ZIZIS Luenue Approximate Interval Batwaan Onsat and Death Gastric Immediata Causa (Final diseesa or condition rasulting In daath) Leiomyo sarcoma Years Dua to (or as a consaquance of) Dua to (or as e consequanca of): Dua to (or as a consequence of) 23b. Did tobacco usa contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings availabla prior to complation of causa of daath? 24a. Was an autopsy performed?

Physician /Medicai Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

To Be

Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health end Mantal Hydene. Important: if flem 27 is marked other than "natural", or items 23s any injury or other traumating account.

Baltimore, Maryland 21215-0020

with the Maryland

physician and s the burial-transit the daath certificate be axecuted O. Box 68760 attending esn detached for u

page 2 certificate Division of Vital Hospital or Attending Physician: director, within 24 hours after death. To the Funeral Diractor: After this funeral

Examiner Physician/Medicai Completed by Certification: pletaly filled in by

edicai

Sequentielly list conditions, if any, laading to immadiata causa. Entar Undarfying Causa (Disaasa or Injury that initiated avants rasulting in daath) Last

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Yas 2 ₽No 26. Placa of Daath (Chack only ona)

1 ☐ Yas 2 ☐ No

25. Was casa rafarrad to medical axaminar? 1 Yas 2 → No 27. Mannar of Death

5 Panding invastigation

28a. Data of Injury (Month, Day Yaar) 6 Could not ba datarminad

Hospital:

28b. Tima of

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)

1 Inpatient 2 ER/Outpatient 3 DOA

Othar: 4 ☐ Nursing Homa 5 ☐ Hasidanca 6 ☐ Othar (Specify) 28c. injury at Work? 1 Yas 2 No

Ave.

28d. Dascribe how injury occurred

Galto: MD

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

(Check only one)

29a, Cartifiar

1 Natural

2 Accidant

4 | Homicida

3 ☐ Suicida

1 Certifying Phyaician: To the bast of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of cartifiar

29c. Licansa numbar 04315 MO

29d. Date signed (Month, Day, Yaar) 3/17 9

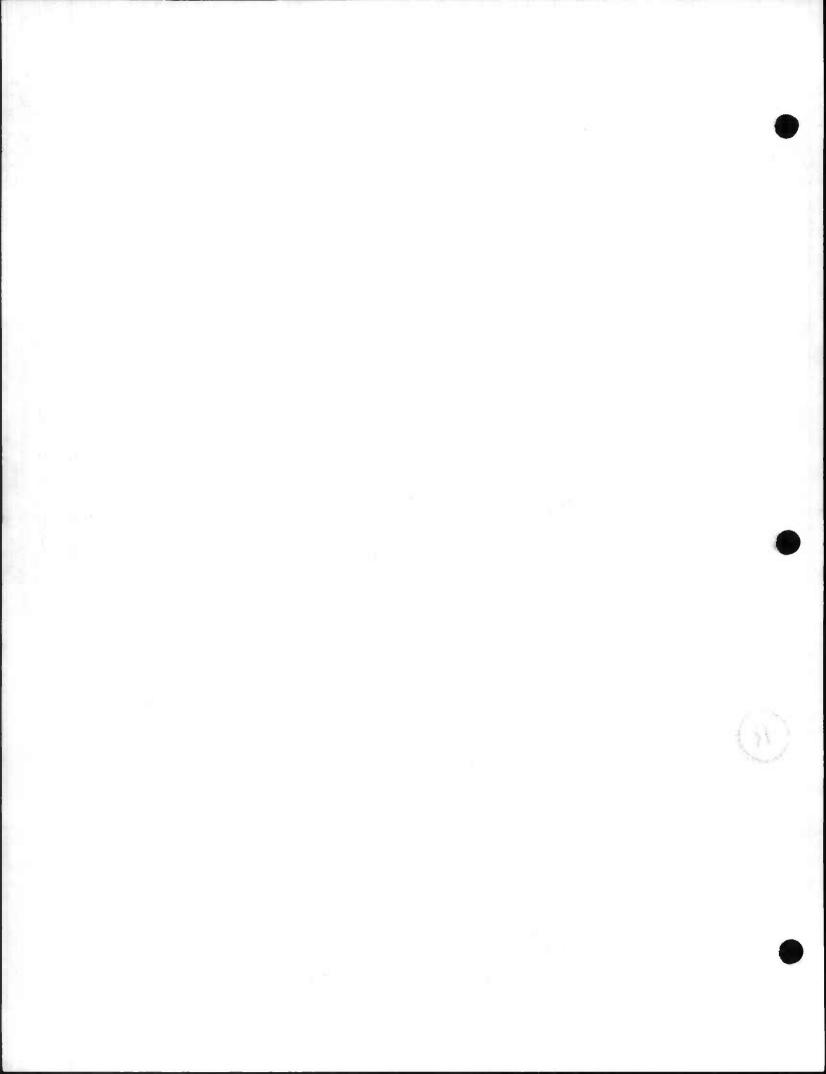
30. Nama and addrass of parson who complated cause of death (Itam 23a) (Type, Print) 1717 6wynn Steven DAK miller

31. Data filad (Month, Day, Year) MAR 1 8 1997

12 Ragistrar's Signature

State Registrar

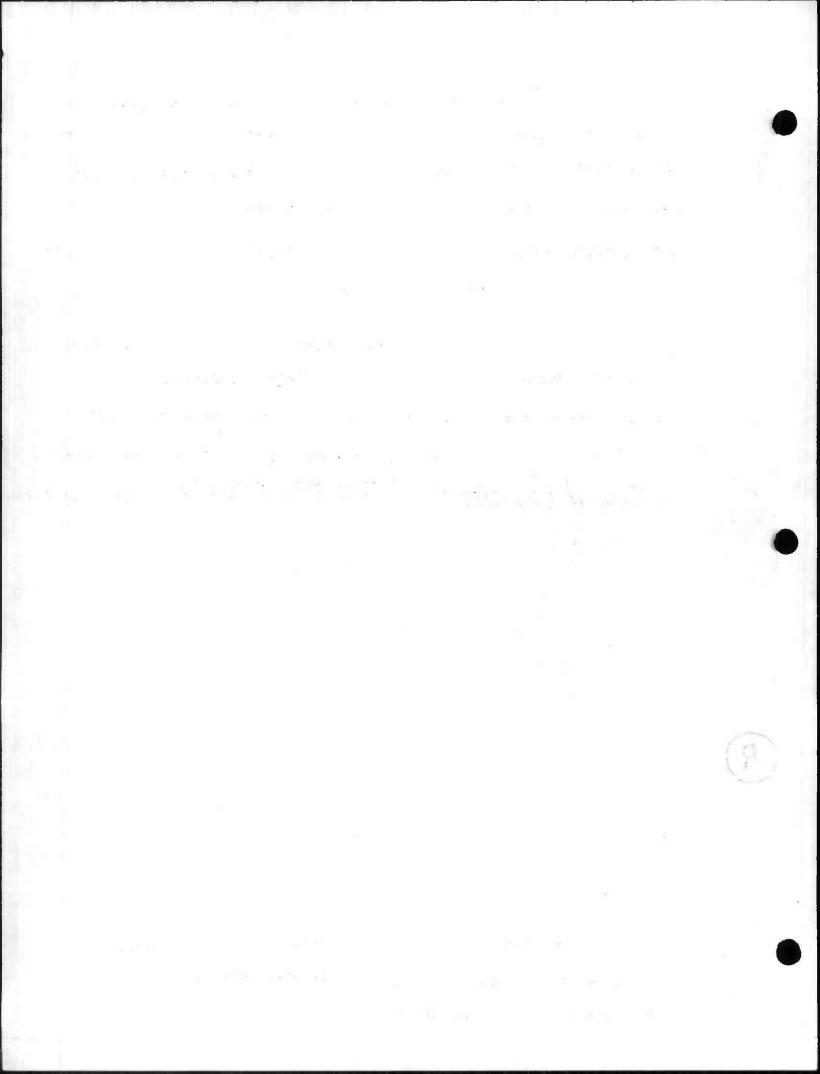
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State of Maryland / Department of Health and Mental Hygiene

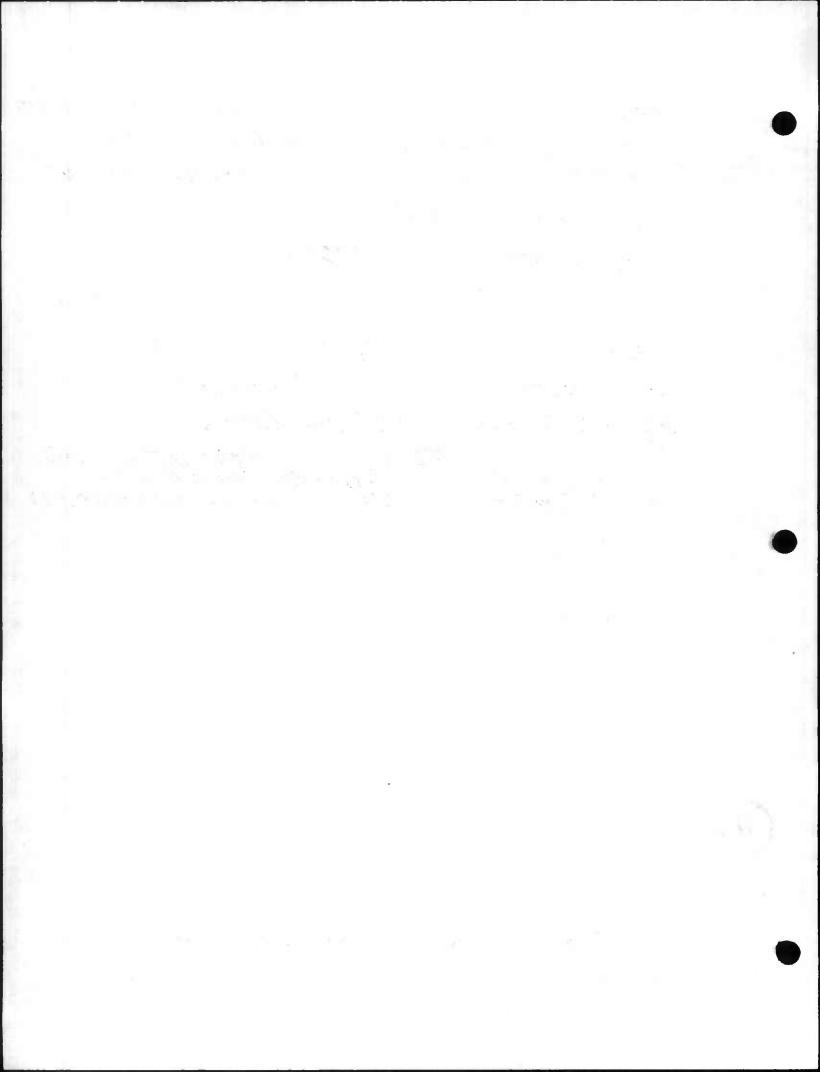
Items8,17 3-31-97 FilmG745 W.H.Per F/H 08145 Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Daath 3. Tima of Death **Physician** Patricia Ann O'Hara Month March 10, 1997 /Medical 4a. Facility Name (If not Institution, give straat and number) 513 E. 28th Street 4b. City, Town, or Location of Death **Examiner** N/A Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 40 9. Birthplace (State or For Country)

July 18, 1944 Maryland Birthplace (State or Foreign Country) **Funeral** 1 ■ M 2 🗓 F 220-34-7390 Yrs. 52 **Director** Usual Rasidanca of Dacedant permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Health end Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other treumatic event, to Medical 10a. Stata 10b. County Maryland 10c. City, Town or Location 10d. Insida City Limits N/A Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 513 E. 28th Street 21211 USA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 22 No If Yas, Giva Yaar or Datas: Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Rece - Amarican Indien, Black, White, etc. Naver Merried 2 Married 1 □ Yas 2 No Specify: white Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 16a, Decedant's Usual Occupation
"Giva kind of work dona during most of working
life. DO NOT use ratired)
Homemaker 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) In Own Home 17. Fathar's Nama (First, Middle, Last) William Whitley 18. Mothar's Name (First, Middle, Maidan Surname) Helen C. Carroll Be ·Joseph H. Heine Carroll 19a. Informant's Neme/Raiationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Steta, Zip Code) Angela Laura Wagner-Friend Rt 1 Box 170D Buckhannon, WV 26201 20a. Method of Disposition
1 □ Burial 2 □ Cremetion 3 □ Removal from Stata 20b. Placa of Disposition (Nama of cematery, cramatory or other place) 20c. Location - City or Town, Stata 3/17/97 BaltimoreMaryland Oaklawn Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signetura of Funerel Service License 22. Nama and Address of Facility
Burgee-Henss Funeral Home
3631 Falls Road Baltimore, Maryland 21211 hasa, or complications that caused tha daeth. Do not anter the mode of dying, such as cardiac or raspiretory errest, the complex cardiac or raspiretory errors are cardiac or raspiretory errors. Approximata Intarval Batween Onsat and Death Physician /Medicai immediata Cause (Final the disaase or condition resulting in daath) **Examiner** Examiner that the death certificate be executed burial-transit Sequentially fist conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaasa or Injury that initieted avants resulting in daath) Last and Dua to (or as a consequence of): the attending physician thed for use es the buria P.O. Box 68760 Physician/Medical Dua to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 9d 5y 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown Completed by 24b. Ware autopsy findings eveilable prior to completion of cause of daath? 24a. Was an eutopsy performed? 1 Yes 2 No 1 Yas 2 No Division of Vital Be Physician 25. Was case referred to medical 26. Piaca of Death (Check only one) 2 1 Yas 2 No Other: 4□ Nursing Home 5 Residence 6 □ Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Mannar of Death Certification: 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Affer Attending 5 Pending invastigation 1 Netural of or Attending after death. Director: Att 1 Tyes 2 □ No 2 Accident 6 Could not ba 3 Suicide 28e. Pleca of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) in by 4 Homicide within 24 hours a To the Funeral D the Hospital Medical 29a. Cartifian 1 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, data and place, and due to tha causa(s) and menner es steted. 2 Medical Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) end manner steted. 29b. Signatura end titla of certifier 29d. Data signed (Month, Day, Year) 29c. Licansa number 0 28266 30. Name and addrass of person who completed causa of death (Item 23e) (Type, Print) Dr. Aye Lwin 5010 YORK, RE 21212 BALTO MA 31. Dete filed (Month, Day, Year) 32. Registrar's Signatura State una Varidson MAR 18 1997 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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28a-f	Director	10e. Street and Number	77	T/A	11/1/01	XE_				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth Month **Physician** SilliW Mac Penson March 14 1997 IZLIZAM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 10 1 stigged Baltmore Baltimore 5. Social Security Number If Undar 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) **Funeral** 10 M 200F Months Days Hours Min 218-22-8792 Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b County 10c. City. Town or Location 10d. insida City Limits must be notified at 1 Yes 2 No Director Baltimore Md 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 3930 enhurs t Avenue 21215 · S.A Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: 7 is marked other than "natural", or items traumatic event, the Medical Examiner m. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritai Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Black altimore, Maryland 21215-0020 1 Yes 2 2€No Specify: þ Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest greda completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Immanany. Bakery Elementary/Secondary (0-12) College (1-4or 5+) Decorator Whyrade NA 17 Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be Brown Kober Maggie 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20b. Place of Disposition (Name of carrietery, cremetory or other place) Caturisulle nd 21228 ugene Cirde 20e. Method of Disposition

1. Burial 2 Cremation 3 Removal from State Dete 20c. Location - City or Town, State Memoral Park 4 ☐ Donation 5 ☐ Other (Specify) 3-19-97 21. Signetura of Funeral Servica Licansee 22. Name and Address of Fecility 23a. Part 1. Enter the disaase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one ceuse on each line. wabash Avenue Approximata Interval Batween Onset and Death **Physician** /Medical 18 hours Immediate Ceuse (Final chronic hemolytic aremia disaesa or condition resulting in deeth) Examiner Examiner certificate be axecuted burial-transit and Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence ot): P.O. Box 68760, physician Physician/Medical the Due to (or as a consequence of) usa as signed by the a Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? 1 ☐ Yes 2 ₽No 3 Probably 4 Unknown Records, þ should be 24b. Were autopsy tindings available prior to Completed 24a. Wes an autopsy completion of cause of death? 1 Yes 2 HNo 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Certification: Affer 5 Pending investigation 1 PNatural death. 1 ☐ Yes 2 ☐ No or Attendi after death Director: A d in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Thomicide To the Hospital o within 24 hours af To the Funeral Di complately filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner steted. 29e. Certifier Medical (Check only 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) AS2402321PG9024 March 14, 1997 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Baltimere, MD Par,cc Green Sinai Hospital

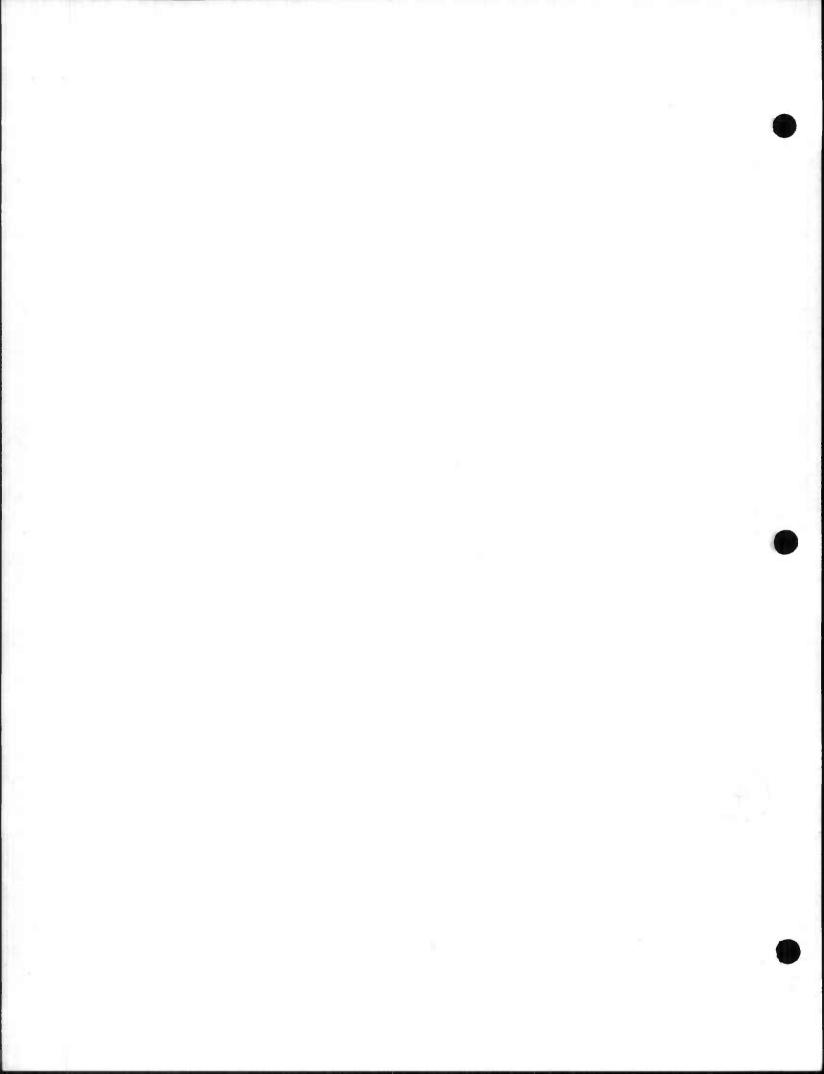
Registrar

State

31. Dete filed (Month, Dey, Year)

32. Registrar's Signature grave Augdson-Randsoll

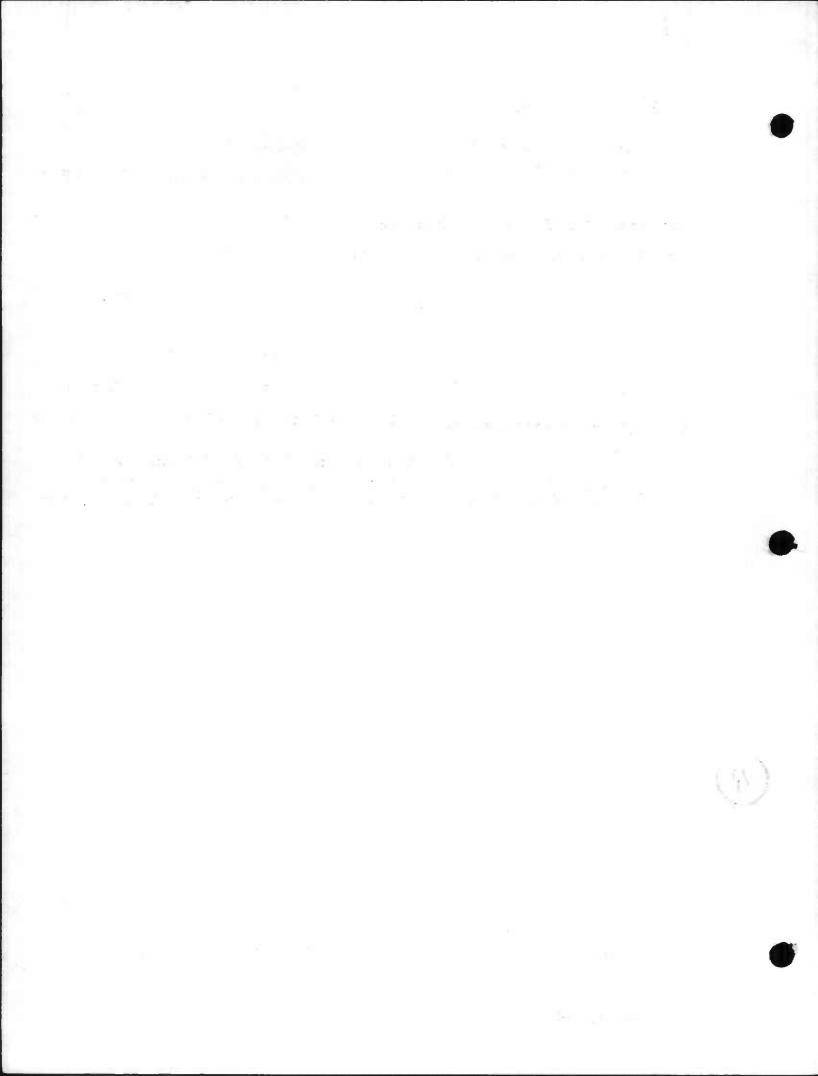
MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Item19b 3-25-97 FilmG745 W.H. Per F/H State of Maryland / Department of Health and Mental Hygiene Item10e 3-24-97 FilmG745 W.H.Per F/H Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month **Physician** 15:00 Everett Phillips 3 15 47 /Medical 4a. Facility Nama (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore If Under 24 Hrs. 8. De NA Center | If Undar 1 Year 5. Social Security Number Medical 6 Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 9. Birthplaca (Stata or Foraign Country) Tennessee **Funeral** 107M 20 F Months Days Hours Min Yrs Director 250-24-4224 7/05/24 Usual Rasidance of Decedant filed within 72 hours after death with the Maryland 10a Stata 10h County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ☐XNo Director Maryland Baltimore Dundalk 10e. Street and Number 7912 10f. Zip Coda 10g. Citizan of What Country? Boundary .7812 North Boundry Road 21222 USA Funeral 12. Was Decedent Evar In U,S. Armed Forcas? 1⊠ Yas 2 □ No If Yas, Giva Yaar or Datas: WW II 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Marriad 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐No Specify: Specify: White Aq 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiena. Important: If item 27 is merked other than "na eny injury or other traumatic event, in a High page. Elemantary/Secondary (0-12) Coilega (1-4or 5+) 9th Body & Fender repair Auto 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Phillips Sarah Eldridge George 19a. Informant'a Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7812 North Boundry Road Dundalk, MD 21222 Virginia M. Phillips/Wife 20b. Place of Disposition (Name of Comatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp 3/17/97 Towson, MD 21. Signature of Funaral Sarvice Licenses 22 Name and Addrass of Eacility 7922 Wise Ave. Dundalk, MD 21222 Duda-Ruck Funeral Home of Dundalk, arborto 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on a single response to the death. Approximata Intarvai Between Onsat and Death Physician /Medical Immediata Causa (Final Rena disease or condition resulting in death) Examiner Examiner Dua to (or as a consequence of): **burial-transit** Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disaasa or Injury that initiated evants rasuiting in daath) Last and attending physician for use as the burie Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequance of): a property the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yea 2 No 3 ☐ Probably 4 ☐ Unknown þ 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 20 No 1 ☐ Yas 1 Yas 2 No 25. Was case referred to medical Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) Physiq 1 Yas 2⊠ No 2 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. Injury at Work? Attending 5 Panding invastigation 1 Natural or Attending the other death. 1 ☐ Yas 2 ☐ No 2 Accident filled in by the 3 ☐ Suicida 8 Could not be 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida To the Hospital o within 24 hours of To the Funeral DI 15 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifian 29b. Signatura and titla of certifian 29c. Licensa number 29d. Data signed (Month, Day, Year) Sunjo 13-10393 30. Nama and addrass of person who complated causa of death (itam 23a) (Type, Print) Baltimore V.A. Kavi 5-4r4 iq 10 North Greene Str. Baltimore, MD 21201 31. Data filed (Month, Day, Year) 32 Registrar's Signature State was Davidson-Randall MAR 1 8 1997 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth 743 AM **Physician** Ernest Singerman
4e. Fecility Neme (If not Institution, give wheet end number) Primaff March 1997 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner LORIEN NURSING HOME COLUMBIA HOWARD 8. Dete of Birth (Month, Dey, Year)
APR. 28, 1913 BROOKLYN, NY 5. Sociel Security Number 6. Sex 1X M 2□ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 83 577-48-7699 Yrs Director Usuel Residence of Decedent the Maryland show 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director CHEVY CHASE MD MONTGOMERY 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5 items 23a 20815 4242 EAST WEST HIGHWAY, /802 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - Americen Indien, Pagas 1 and 2 should be filed within 72 hours aftar nent of Hastlih and Mentel Hygiene.
ant: If item 27 Is marked other than "natural", or ite any or other traumatic event, Ita Medical Examine ury or other traumatic event, Ita Medical Examine Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: WHITE Specify. by 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Educetion (Specify only highest grede completed) 16e. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RESEARCH PROJECT DIRECTOR SERVICE COMMISSION 12 9 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be WALTER PRIMOFF JULIA SINGERMAN 2 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 4242 EAST WEST HIGHWAY, CHEVY CHASE, MD 20815 JOHN PRIMOFF (SON) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 1) ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) permit. Page Department of Important: If any Injury or CHESTNUT/GROVE CEMETERY 3-3-97 HERNDON, VA. 2. Name end Address of Fecility GREEN FUNERAL HOME, 721 ELDEN ST., HERNDON VA. sase, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, in. List only one hause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical immediete Ceuse (Finel 12 elastic Parcelia Cancel diseese or condition resulting in deeth) J Yrs Examiner Examiner burial-transit in the requires that the death certificate be axecuted Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medical the Due to (or es e consequence of) 8 USB Part il. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco usa contributa to the cause of death? ate has been signed by page 2 should be detacl 1 Yes 2 No 3 Probably 4 Unknown Mellit Records, þ Be Completed 24b. Were autopsy findings aveilable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2 N 1 Tyes 2 No 25. Wes case referred to medical 26. Place of Qeeth (Check only one) 2 1 Yes 2 Jul Other: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 27. Menney of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred 1 Naturai 5 Pending investigation death. Divisio 1 Yes 2 No Attendi 2 Accident after death filled in by tha 3 Suicide 6 Could not be determined 28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 T Homicide 5 24 hours Hospital 29e. Certifier 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner es stated. To the Hosp within 24 hor To the Fune completely fi 2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end menner stated. (Check only one) 29b. Signature and title of ceptifier 29c. License number 29d. Dete signed (Month, Dey, Year)

Marce 10, 1997

CKU4312 MD 21045

Registrar

State

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

MAR 1 8 1997

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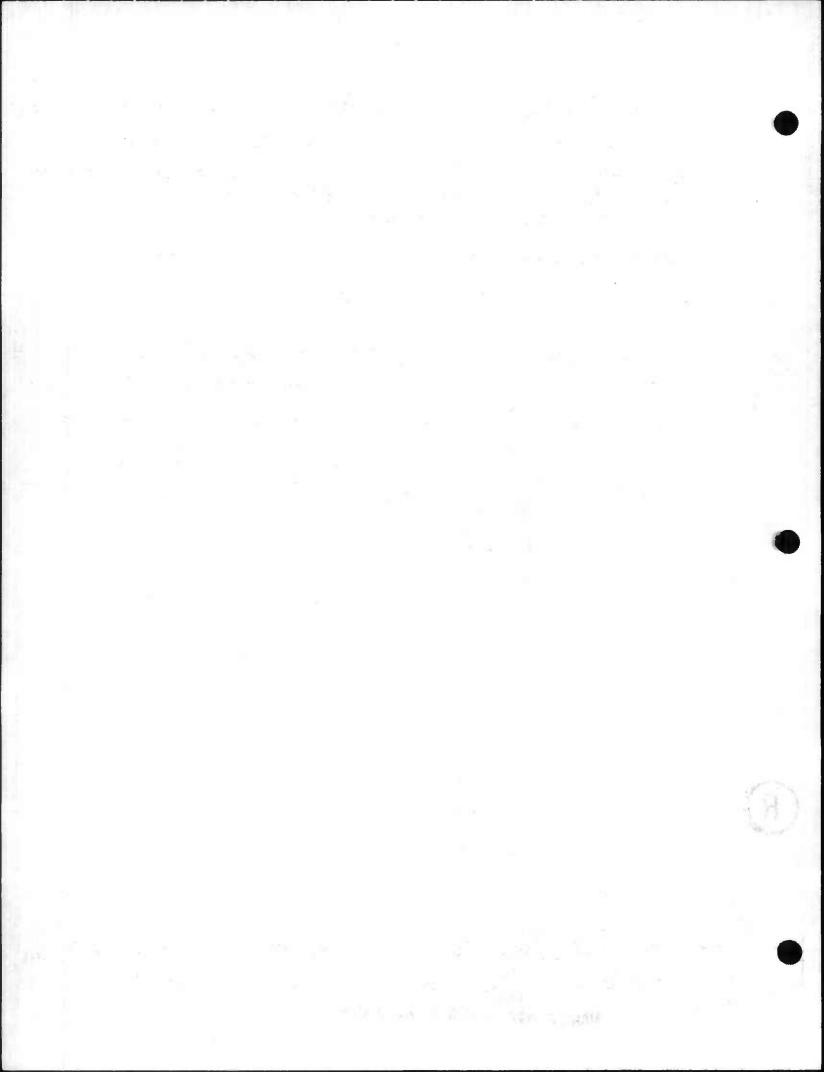
32. Registrer's Signeture

NOR74

Julia Devidson

CHENG

31. Dete filed (Month, Day, Yeer)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10:55 a.m Ethel Mahalay Parkinson 1997 Mar 14 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Country House LTD Anne Arunde1 Harwood if Under 24 Hrs. 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Days 1□M 2⊠F Hours 99 214 74 5333 Yrs Sept 21 1897 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Annapolis X Yes 2 No 10e. Street and Number 410 Monterey Avenue 10f. Zip Code 10g. Citizen of What Country? Annapolis 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritai Status Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 ☐ Divorced Year or Dates: 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 6th Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Sewell Margaret Burns 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold Parkinson 410 Monterey Ave., Annapolis, Md 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State # Burial 2 □ Oremans. 4 □ Donation 5 □ Other (Specify) Hillcrest Cemetery 7 Annapolis, Md 3/17 21. Signature of Furniral Service Licensee 22. Name end Address of Fecility Hardesty Funeral Home PA Annapolis, Md 12 Ridgely Ave, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heer failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting In death) Due to (or as a consequence of): Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as a consequence of): Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No 24b. Were autopsy findings ayafleble prior to completion of cause of death? 24e. Wes en autopsy performed? 2010 1 Yes 1 ☐ Yes 2 ☐ No 28. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred

Examiner physician and s the buriel-transit that the death certificate be executed Records, P.O. Box 68760, physician 100 980 ò the ghed by ã Division of Vital

Physician /Medical

Examiner

Physiclan/Medical þ Completed Be 2 Medical Certification:

Physician

/Medical

Examiner

Director

Funeral

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Funeral

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item 27 is merked other than "natural", or items 23a or 28a-f show other traumstic event, the Modical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after deeth a Department of Health and Mental Pygiene. Important: If item 27 is merked other than "natural", or Items 23s eny injury or other traumatic avant

Baltimore, Maryland 21215-0020

with the Maryland

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manger of Death 5 Pending Investigation 1 Natural 2 Accident 6 Could not be determined

3 Sulcide

29a. Certifier

4 Homicide

(Check only one)

30. Name and add

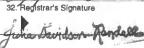
29b. Signature end title of certifier

wirth

31. Date filed (Month, Day, Year)

To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Alter this certific

State Registrar



50

ss of person who completed cause of death (Item 23a) (Type, Print)

8

28c. Injury at Work?

28b. Time of Injury wr 0 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number Rural Route Number, City or Town, State) Piace of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Md 20776

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month RAWLES VIOLA 6:42 pm MARCH 1997 16 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CENTER HOSDITAL BALTIMORE Baltimore City HARBOR 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign Deys 1□M 2□F 219-20-8630 69 YES March 25, 1927 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10o. Citizen of What Country? 21225 U.S.A. 4107 Rondo Court 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ₩ Widowed 4 Divorced **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Driver Ronald McDonald House 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Johnson Joseph M. Butler Gladys 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Straet end Number or Rural Route Number, City or Town, Stete, Zip Code) 348 Highland Drive Apt 101 Glen Burnie, Md. 21061 Ray Rawles (Son) 20b. Place of Disposition (Name of cemetery, crematory or other p 20e. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Baltimore NATIONAL Cem. 3/20/97 Baltimore, Maryland 21. Signeture of Funeral Servica Licensee 22. Name and Address of Fecility Kevin E, Ecker McCully FuneralHome of Brooklyn 237 E. Patapsco Ave. Balto., Md. 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, April 235 April 236 April 236 April 237 E. Patapsco Ave. Balto., Md. 21225 April 238 Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK 2 DAYS disease or condition resulting in death) Due to (or es e consequence of): > 1 month. GANGRENE RIGHT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Lest YEAR PERIPHERAL VASCULAR DISEASE Due to (or as e consequença of): RENAL FAILURE 1 YEAR CHRONIC 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS 24b. Were autopsy findings available prior to 24a. Was an autopsy HYPERTENSION completion of cause of death? 2 19 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Examiner bunial-transit Physician/Medical

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Certification: To

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ris 23a

Baltimore, Maryland

P.O. Box 68760,

Records,

Division of Vital

Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica

funeral

filled in by

within 24 hours a To the Funeral D completely filled

To the

permit. Pages 1 and 2 should be in Obepartment of Health and Mental important: If Illem 27 is merked of any Injury or other traumatic eve

Physician /Medical

Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

investigation

6 Could not be determined

1 Yes 2 No 27. Manner of Death

28a. Date of Injury (Month, Day Year) 5 Pending

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier

1 Neturel

2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MAR 1 8 1997

L. Shomen - Intern - Medicine

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

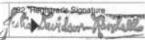
29c. License number AS 2441614-38

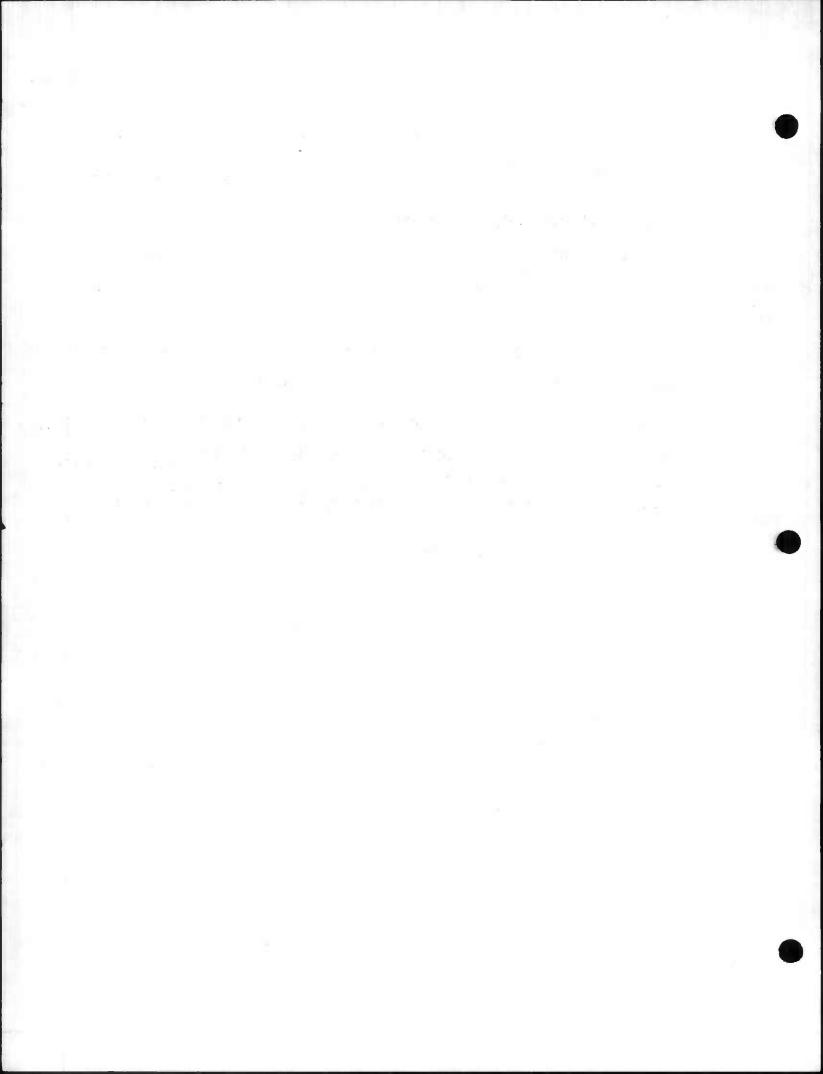
29d. Date signed (Month, Day, Year) MARCH-16-1997.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIZY THOMAS, HARBOR

HUSPITAL CENTER, BALTIMORE, MD.

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month 13 1997 HERMAN KUOCK 1206 PM. March 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore If Under 24 Hrs. 8. Dat Conter Baltimore City Biotholace (State or Foreign H0521401 HALPOL 5. Social Security Number Age (In yrs. last birthday) 78 Yrs. If Under 1 Year 8. Date of Birth (Month, Day, 1**X**0 M 2□ F Months Deys Hours Min. Nov. Maryland 216-14-0769 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. 1 Yes 2 No Baltimore Anne Arundel 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 405 Holy Cross Road U.S. A. 14. Race - American Indien, 21225 12. Was Decedent Ever in U,S. Armed Forces? 1 V Yes 2 No If Yes, Give Year or Dates: WW I I 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 □ Widowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Stationary Engineer 6th Boston Naval Ship Yard 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Lannie F. Ruark Virgie P. Travers 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elvira E. Ruark (Wife) 405 Holy Cross Road Balto., MD. 21225 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cedar Hill Cemetery 3/19/97 Baltimore, Maryland 21. Signature of Funeral Service Licensee Kevin E. Ecker 22. Name and Address of Facility McCully Funeral Home of Brooklyn 237 E. Patapsco Ave. Balto., MD. 21225 approximate shock, or heart failure. List only one ceuse on each line. Immediate Ceuse (Finat (os min disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contributa to the causa of death? Szeondary to Colon CareinoMA 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 25 No 25. Was case referred to medicel 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred

Physician /Medical **Examiner**

The law requires that the death certificate be executed

P.O. Box 68760.

Records.

of Vital

Division

Physician

/Medicai

Examiner

10a. State

Director

Funeral

Completed by

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Funeral

Director

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Baltimore, Maryland

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Examiner sician and burial-transit physician s the buria

Physician/Medical λq Completed Be 2

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certificata Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director filled in by the funeral within 24 hours a To the Funeral D completaly filled Medical pletaly

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s of perso

1 Neturat

2 Accident 3 Suicide

4 Homicide

(Check only one)

29a, Certifier

29b. Signature end title of certifier who completed cause of death (Item 23e) (Type, Print)

M.D.

28e. Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basts of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

March 15 1997

ARFECY C 31. Date filed (Month, Day, Year) Gimbel

5 Pending

investigation

6 Could not be

3001 S. Hanover St. Baltimore MD.

1 ☐ Yes 2 ☐ No

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Deeth 3. Time of Deeth Physician Month Clarke Rushing 1019 March 199-11:00 AM /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD If Under 1 Yeer If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthdey) 6. Sex Birthplace (Stete or Foreign Country) **Funeral** 1 ☐ M 2 🛱 F 87 Yes Director 213-80-0071 PA Usuei Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Manyland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be nutried at 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits MD HOWARD COLUMBIA Director 1 ☐ Yas 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6436 BELLEVIEW DRIVE 21046 U.S.A. Funeral Race - American Indien, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxicen, Puerto Rican, etc.) 1 Never Married 2 Marriad 1 ☐ Yas 2 ऒ No If Yas, Give Yaer or Detas: Baltimore, Maryland 21215-0020 1 Yes 2\No à Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mothar's Name (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) WILLIAM CLARKE MARTHA LOGAN 19e. Informent's Name/Reietlonship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) FRANK C. RUSHING (HUSBAND) 6436 BELLEVIEW DRIVE COLUMBIA MD 21046 20b. Plece of Disposition (Name of cametary, cramatory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Buriel 2 Cremetion 3 ☐ Ramovel trom Stete CHESAPEAKE CREMATORY MAR. 17, 1997 4 □ Donetlon 5 □ Other (Specify) BELTSVILLE MD 21. Signature of Funarel Sarvice Licansee 22. Neme and Address of Fecility WITZKE FUNERAL HOME, INC. OF COLUMBIA 5555 TWIN KNOLLS ROAD COLUMBIA MD 21045 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arreat, shock, or heert tailure. List only one gause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disaasa or condition resulting in death) respirator Examiner Due to (or es a conse neumonia attending physician end for use as the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical Due to (or es a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? ingned by 1 Yes 20 No 3 Probably 4 Unknown failure Renal à 8 24a. Wes an eutopsy performed? 24b. Were autopsy tindings aveilable prior to completion of cause of deeth? Completed page 2 1 ☐ Yes 2 No Division of Vital 25. Was case reterred to medical examiner?
1 ☐ Yes 2 No Optiff Be 28. Place of Deeth (Check only one) To the Hospital or Attending Physicia within 24 hours after death.

To the Funeral Director: After this cent completaly lilled in by the funeral direct Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 2 ER/Outpetient 3 DOA 27. Magner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of Medical Certification: 28c. Injury et Work? 1 Netural 2 Accident 5 Pending investigation 1 Yes 2 No 3 Suicide 6 Could not be 28e. Pleca ot injury - At homa, ferm, street, fectory, offica building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signeture end title of certities 29c. License number 29d. Date signed (Month, Dey, Year) March my 30. Nema and address of person who completed cause of deeth (Item 23e) (Type, Print) Geller mo Ellicott City MO 9501

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32. Registrer's Signetura

& Rie Davidson

Annapolis Rd

DHMH 16 Ray 6/95

State

Registrar

31. Dete tiled (Month, Day, Yeer)

MAR 1 8 1997

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedeni's Neme (First, Middle, Last) 2. Date of Death Stinson-Allen March 15 **Physician** nna /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MEMORIAL HOSPITAL HARVE DE GRACE HARFOLD HARGOFD Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign (Month, Day, Year) 1 A Yrs. Months Days Hours Min. FEB 4, 1935 N. CAROUNTU 5. Social Security Number **Funeral** 239-34-4549 Usuel Residence of Decedeni Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at DE GRACE HARVE HATTOKO 1 Tes 2 No Mary LAND 10e. Street and Number, 10f. Zip Code 10g. Citizen of What Country? 21078 filed within 72 hours efter death with 901 ERIE U5A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, permit. Peges 1 and 2 should be filed within 72 hours efter di Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or item any injury or other traumatic event, the Medical Examines. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Merried 21215-0020 1□ Yes 2☑No þ Specify: Black 3 ☐ Widowed 4 ☑ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry US AKMYAPG Elementary/Secondery (0-12) Gollege (1-4or 5+) Mathematician Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Buchmon Willie LEG Brogan BAYTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) ABINGCION, Ded 21009 3/06 TIPTON WAY altimore. Deta/ 200. Location - City or Town, State
3/2/19 HAR US DE Grace Red 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Arrived BEATO FUNERAL SERVICES
SE LEW'S STREET, HATY COMP 21078 21. Signature of Funeral Service Licensee HARUG DE 23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. Liat only one cause on each line. **Physician** Immediate Ceuse (Finel diseese or condition resulting in death) /Medical bu hours Cerebo vascular Accedent **Examiner** Due to (or es e consequence of): Coronary Atemy Disease
Due to (or as e consequence of): et the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lasi Box 68760, Physician/Medical Due to (or as a consequenca of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Drabetes Mellitus Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Anemia 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physician: 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1☐ Yes 25 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Natural deeth. 1 ☐ Yes 2 ☐ No 2 Accident after deeth Director: / filled in by the 3 Suicide 6 Could not be determined 28e. Placa of Injury - Ai home, farm, atreei, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide within 24 hours a To the Funeral C completely filled Medical 15 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

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Murzarnus

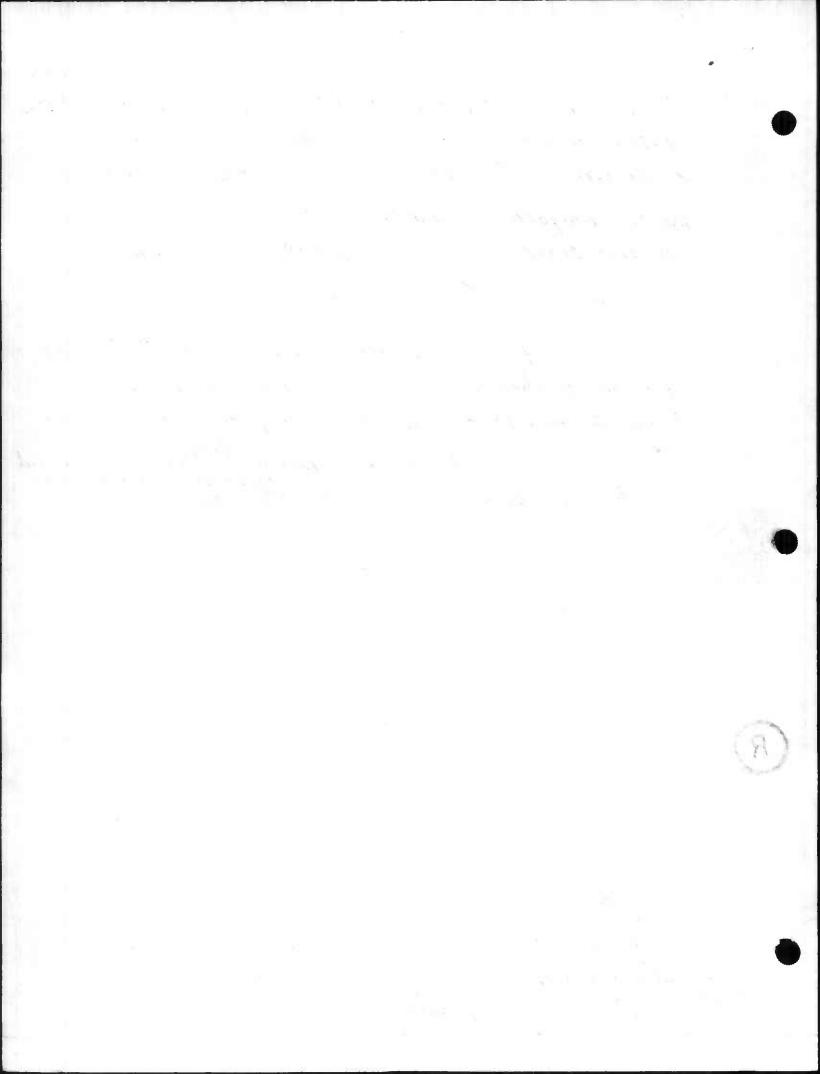
MIRZA A. BAIG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



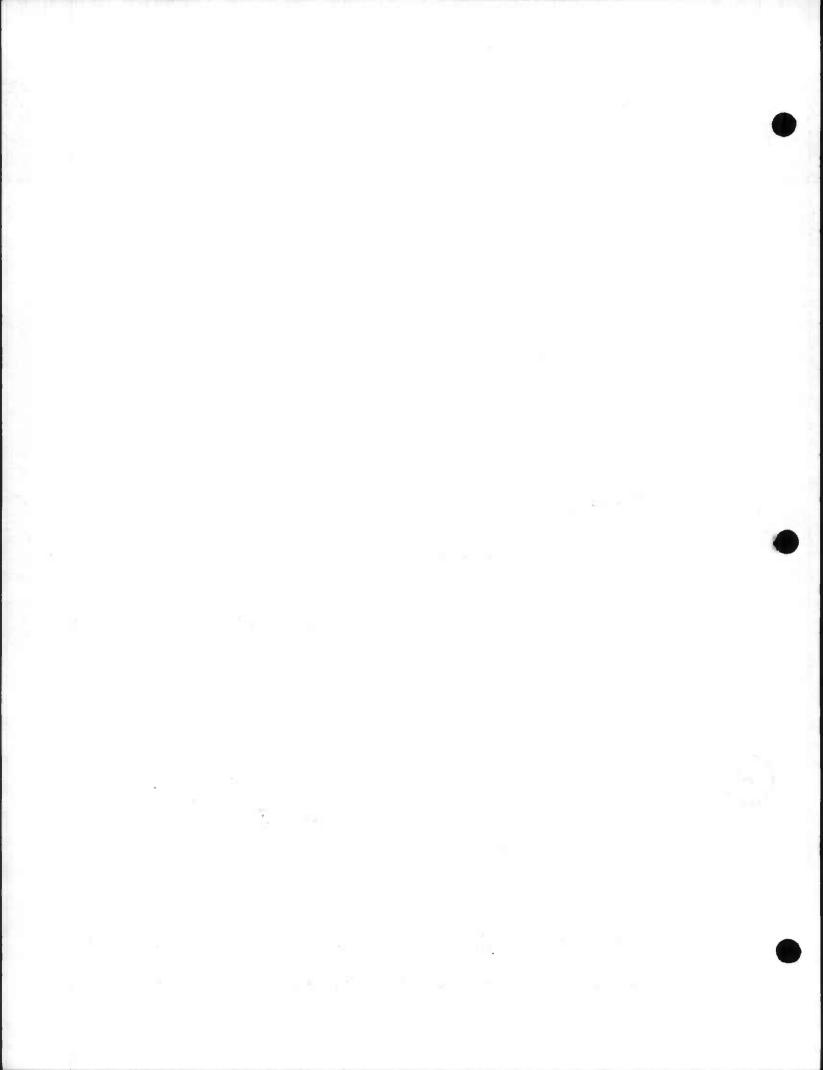
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State of Maryland / Department of Health and Mental Hygiene 97 08155

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N B Vellanki, MD, 9055, Chevrolet Drive, #Suite 100, Ellicott City, MD 21042.	,	1		30. Name and address of parson who are	moleted cause of death floor or	le) /Tuna D-int)	2 30		1				_
Ot Date filled (Marsh Day Marsh		V					#S111 +	- 100 I	ellicott	City	MD 210	142	
Allenda com N. Mr. La		Sta		31. Dete filed (Month, Dey, Year)			,, JULE	, 1		0_011			



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev **Physician** Month Yeer 5:20PM Marie E. Stecker 16, 1997 4c. County of Deeth /Medical March 4e. Fecility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 317 Prospect Bay Drive Grasonville Oueen Anne If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (Stete or Foreign Country) **Funeral** 1□ M 2CXF Yrs. Director 65 216-28-7267 Dec. 5, 1931 maryland Usuel Residence of Decedent netified at 10e State 10b Counts 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 ☑ No Director Md. Queen Anne Grasonville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 317 Prospect Bay Drive 21638 Funeral U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 □ Never Married 2 □ Married 1 Yes 2 No If Yes, Give Yeer or Detes: 8 Specify: White Baltimore, Maryland 21215-0028 1 ☐ Yes 2 ☐ No þ 3 1 Widowed 4 □ Divorced 72 hou Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12th Receptionist Bank Peges 1 and 2 should be filed tent of Heelth end Mentel Hygi nt: if tem 27 is marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surname) Be William Scheeler Clara Fischer 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Department of Heelth er Important: If Item 27 is any injury or other tratonce. Mrs. Kathi L. Eikenberg 317 Prospect Bay Drive Grasonville, Md. 21638 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☑ Buriei 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Parkwood Cemetery 3/19Baltimore, Md. 21. Signature of Funerel Service Licensel 22. Neme end Address of Fecility Hartley Miller Funeral Home 7527 Harford Rd. BAltimore, Md. 21234 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, and or hear feilure. List only one cause on each line. Approximete tnterval Between Onset and Death **Physician** /Medical tmmediete Cause (Finel COLON CAREENOMA disease or condition resulting in deeth) Examiner Due to (or es e consequence of) The law requires that the deeth certificate be executed physician end s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Due to (or as e consequence of): attending p signed by the a Pert ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No. 3 Probably 4 Unknown þ should l 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes an autopsy performed? Completed certificate hes b 2 10 No 1 Yes 1 Yes 2 No I or Attending Physician: after death. Director: After this certifica director. 25. Wes case referred to medical examiner? Be 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Desidence 8 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Maturel 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigetion rector: / 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in edical Estifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated. 29b. Signeture end title of certifies 29c. License number 29d. Dete signed (Month, Day, Year) March 17,1997 30. Name end eddress of person who ompleted cause of death (Item 23a) (Type, Print)

State Registrar Eric

31. De

Ciganek,

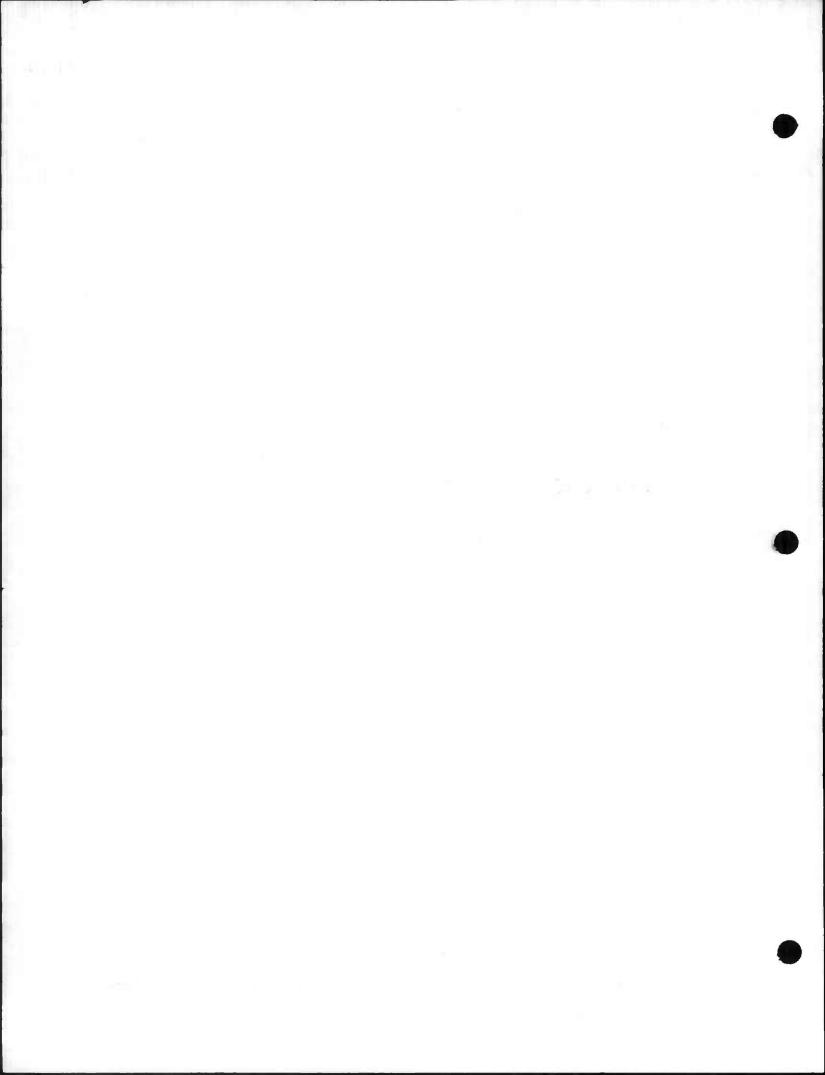
2540 Centreville Rd., Centreville, Md. 21617 2. Registrar's Signeture guing Davidson

	B.K.S	5		riease	State of M		d / Depa	artment of	Health and		•	D . Tree	08157
			1. Decedent's Nem	e (First, Middle, L	ast)		Cei	tificate o	f Death	2. Dete of D			3. Time of Deeth
	Physici /Medi	cal	MARK	EDWA	RD SME]	LTZE	R		4b. City, Town, or	MARCI Location of Des	Day H 15, 1 th 4c. County	997	1:55PM
	Examir	ner	416 ST	RATFORD	ROAD			Williadar 1 Van	BALTIMO	ORE	BAI	TIMOF	
	Funeral Director	Г	5. Social Security N 218-70- Usual Residence of	2212	X	e (In yrs 27	last birthday) Yrs.	If Under 1 Yes Months Day		(Month, E	oy, Year) 1969	9. Birthple Country Penns	ca (State or Foreign y) ylvania
	Marylend H ahow	tor	10e. Stete MD	10b. County Baltin	more	10c. City	y, Town or Lo Cate	cation onsvil	le			100	d. Inside City Limits 1 ☐ Yas X☐ No
	ath with the Maryler 23s or 28s-f show	I Director	10e. Street end Nu	mber	Road			10f. Zip Code 21228	2		10g. Citizen of	Whet Country	n
020	after des	by Funeral	11. Marital Status	ied 2⊡ Merried	12. Was Decedent Armed Forces? 1 Yes 25 If Yes, Give Year or Dates:		f		Hispanic Orlgin? (S ben, Maxican, Puar	Specify Yas or N to Rican, etc.)		ce - Amarican ck, White, etc	c.
1215-0020	within 72 hours no. hen "netural", "Med cal Exe	Be Completed	(Special Special Speci	15. Decedent's E cify only highest gr andary (0-12)	ducation ada completed) College (1-4or 5	5+)	(Give life. L		e during most of wo red)	rking	16b. Kind of B		
yland 2	0 % 0 >	Be Co	17. Fether's Neme	(First, Middle, Las				ivery I	18. Mother's Ne		Pizza e, Melden Surner	ne)	very
Maryle	d 2 should be the end Mental in a marked or traumatic eve	To	19e. informent's Ne Peggy L.	eme/Relationship		.tze:	19b. Mailin		Pegg et and Number or R d Rd. Cat	u <i>ral Rou</i> te Num		, Stete, Zip C	code)
nore,	permit. Pages 1 and 2 should b Department of Health and Ment Important: If Item 27 is marked any injury or other traumatic a once.		20a. Method of Disp	position	Removel from State	C	lace of Dispos ametery, crem	sition (Neme of netory or other pi		Date	20c. Location	- City or Town	
Dailimor	Departme Importar any injur		21. Signeture of Fu		nsee // n	H	33 M	Neme and Add acNabb	ress of Fecility Funeral H erick Rd.	ome, P.	Baltin		עוי
	Physician /Medical Examiner ponujej-trausit	Examiner	immediate Cause (disaasa or conditior resulting in deeth) Sequentially list confirm, leading to impause. Enter Unde	(Final n	b	Due to (o	r es a conseq	uence of):					ntérvel Between Onsat and Deeth
04 00/00,	h certificate be ex anding physician use as the bune	edical	cause. Enter Unde Ceuse (Disease or thet initiated events resulting in death) I	injury	d	Dua to (or	es a consequ	vance of):					
0.5.	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	y Physician/M	Pert ii. Other signif	icent conditions (contributing to death be	ut not resu	ulting In the un	derlying cause g	given in Pert f.		tobacco use co		he cause of death?
STOOP	law requires nas been sign e 2 should be	ompleted by								24e. We	s an eutopsy formed?	availe	a autopsy findings able prior to pletion of cause leth?
Ē	ysician: The lav s certificate has director, page 2	e C	25. Wes çase refer	red to medical					26. Plece of De		Yes 2 No	100	Yes 2□ No
5	Phys ral di	n: To B	examiner? 1 X X es 2 = 2 27. Menner of Death 1 Nature		Hospitel: 1 inpatie 28e. Date of injur	У	ER/Outpetien 28b. Time of Injury	3□ DOA O	Hher: 4 Nursing I	lome X5X Ras	sidance 8 Oth		
	Attender deat ector:	Certification:	2 Accident 3 Sulcide 4 Homicide	investigatio	3-15-	97 Jry - At ho	Apprex E	56b 1E	☐Yes 2 No	281 Location	(Street and Number, Stete)	ber or Rural F	Foute Number,
gar an	To the Hospital or within 24 hours after to the Funeral Director completely filled in	edical (29a. Certifier (Check only one)	1□ Certifying Pt	nysician: To the best on miner: On the basis of and menner sta	exeminet	vledge, deeth	occurred et the estigetion, in my	time, dete end place opinion, death occ	e, end due to the urred et the time	e ceuse(s) end me, dete end plece,	enner es stet end due to th	ed. ne cause(s)
	To the comp	Me	29b. Signeture and	title of certifier	1. Wright	- MI	D		C.M.E		29d. Date signe MARCH		
	10		30. Neme and eddre DoNAL C	ess of person who	completed cause of de	D 1	23e) (Type, F 11 Per	orint) nn Stre	eet, Bal	timore	e, Mary	land	21201

State Registrar

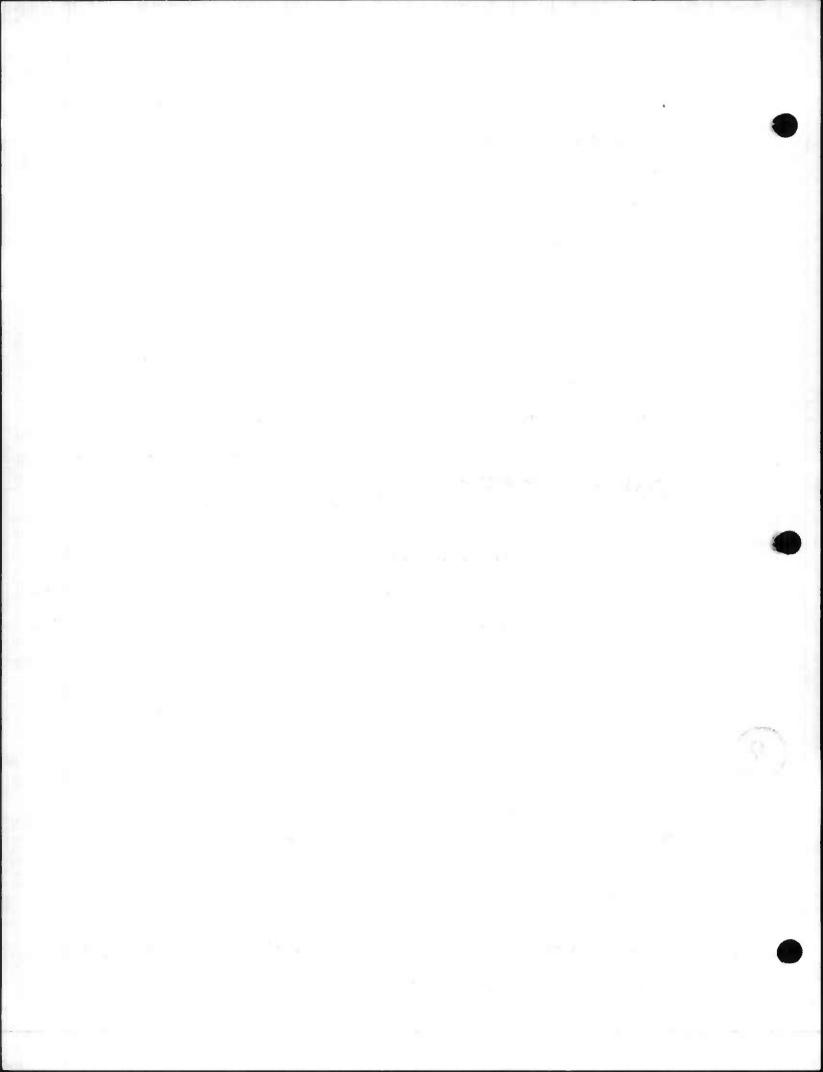
31. Dete filed (Month, Day, Year)

32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene

					Cert	ificate of	Death		Reg. No.	91	0815	
Physic	ion	1. Decedent's Name (First, Middla, Li	ast)			^ .		2. Date of D Month		Year	3. Time of Deal	
/Med		Robert				bup2	ek	MARCH	13, 199	7	11:32 A	
Exam	iner	4a. Facility Name (If not institution, gi					4b. City, Town, o	r Location of Dea	th 4c. Count	y of Death		
	,	THE JOHNS HOPKIN				M	BALTIMO		N/A			
Funera Director	_		Sax 7. Ag 1](Ω M 2□ F	e (In yrs. last bi 85	rthday) Yrs.	Months Days			irth 11, 1911	Cou	place (Stata or For htry) nsylvania	
Maryland a-f show	tor	Washington 10b. County DC N/A		10c. City, Town or Location Washington					10d. Inside City Limits 11 Yes 2 □ No			
h with the	ai Director	10e. Street and Number 3025 Dumbarton St	., N.W.	., N.W.		10f. Zip Code 2000	7		10g. Citizen of USA	What Cou	ntry?	
21.215-0020 within 72 hours effer death with the Maryland ene. than "natural", or items 23e or 28e-f show the Maryland Examine mail be notified at	by Funeral	11. Mantal Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	1 XYes 2 No			as Decedent of Yes, specify Cul	Hispanic Origin? Dan, Mexican, Pus Specify:	(Specify Yes or Narto Rican, etc.)		ce - Ameri ack, White, thy: Whi	etc.	
72 h 72 h natu	etec	15. Decedent's E (Specify only highast gr		16a	. Decede	nt's Usual Occu	pation	orkina	16b. Kind of E	Business/In	dustry	
	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		(Giva kind of work dona during most of work life. DO NOT usa ratirad) Television Producer					ction Company		
be filed at the district of other event,	Be	17. Father's Name (First, Middla, Last	")		18. Mother's Nar			ame (First, Middla, Maidan Sumama)				
aryland should be f and Mental I s marked of rumatic eve	To	Victor Saud	ek				F	edora V	Volfe			
re, Marylc 1 and 2 should Health and Mer am 27 is marke other traumatic		19a. Informant's Name/Relationship (Stephen L. Saudek				ailing Address (Straat and Number or Rural Route Number, City or Hill St. Lexington, MA 02173				or Town, Stata, Zip Coda)		
Baltimore, N permit. Pages 1 and Department of Health important: If item 27 any injury or other to		20a. Method of Disposition 1 Burial 2 Cramation 3 4 Donation 5 Other (Special			f Disposition (Nama of ry, cramatory or othar place) Crematory, Inc. 3/15/97 Baltimore,							
Demit. Departmineorta any inju		21. Signature of Juneral Service Lies George E. Maci	make		22 C1	Name and Addr		y of Mar	yland,	Inc.		
3		23a. Part1. Enter the disease, or com shock, or heart failure. List only		the daath. Do						2122	Approximate	
Physician		shock, or heart failure. List only	one cause on each lin	10.							Interval Between Onset and Death	
/Medical Examiner	ŀ	Immediate Cause (Final disaase or condition resulting in death) Due to (or as a consequence of):									Shour	
	ē			al Fai						1	3weer	
outed nd ransi	Examiner	Sequentially list conditions	U.	ence of):					2 MAGE			
certificate be executed rding physician and use as the buriel-transit											phony	
BOX 06/00, eath certificate be executed attending physician and I for use as the buriel-transit	n/Medical											
hat the death of death of death of death of death of detached for us	Physician/	Part II. Other significant conditions of	contributing to death bu	ath but not resulting in the underlying cause given in Part I.				23b. Did	l tobacco uae co	ontribute t	o the cause of dea	
that the demonstrate be detached	by Ph						1 Yes 2 No 3 Probably					
R	Completed							24a. Wa peri	s an autopsy formed?	av	ere autopsy finding allable prior to impletion of ceuse death?	
	Con							1 XYes 2 □ No		1[1 ☐ Yes 2No	
ysician: s certificat director, p	Be	25. Was cese referred to medicei examiner?					26. Place of D	ona)				
- S 00	2	1 ☐ Yes 2 XNo	Hospital: Inpatie	nt 2 ER/Ou	utpatient	3□ DOA Ot	her: 4 Nursing	Home 5 ☐ Rea	idence 6 🗆 Ot	har (Specia	(y)	
Attending Physical Colors of the funeral by the funeral		27. Manner of Death 1 X Natural 5 Pending 2 Accident investigation	n	pate of Injury Month, Day Year) 28b. Time of Injury M		28c. Inju Wo M 1	nyat ork?]Yes 2∭TNo			ibe how injury occurred		
or Attending a street death. I Director: After death d	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify)							(Straaf and Num own, Stata)	ber or Rur	al Routa Number,	
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	n occurred at the time, date and place, and dua to t vestigation, in my opinion, death occurred at the time			the cause(s) and manner as stated. me, date and place, and due to tha causa(s)						
To the To the Comp	Σ	29b. Signatura and title of certifiar				29c. Lican	se nu <i>m</i> ber		29d. Date signed (Month, Day, Year)			
<u>.</u>		manush	edando	5		RE	ES-000		mara	13	1997	
10		30. Name and address of person who	completed ceuse of de	eath (Item 23a)	(Type, Pr	rint)	thmore	amo	21205			
St Regist	ate rar	31. Date filed (Month, Day, Yaar) MAR 1 8 1997	July Ju	s Signature	place	1						



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dey **Physician** 16, Grace Schlesinger 1997 March 8:30 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Cherrywood Nursing & Rehabilitation Center Reisterstown Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 90 Yrs. 8. Date of Birth Month, Day, Year JAN 14, 1907 9. Birthplace (State or Foreign Country) New York **Funeral** 1□M 20 F Months Days Hours Min. Yrs. Director 217-30-2868 Usuai Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits r than "naturel", or Items 23a or 28a-f ehow the Medical Examiner must be notified at MD Director Baltimore 1 ☐ Yes 2√2 No Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12020 Reisterstown Road Funeral 21136 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marltal Stetus filed within 72 hours efter 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 21 No Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Eiementary/Secondary (0-12) Coilege (1-4or 5+) permit. Pages 1 and 2 should be filed will Depertment of Health and Mentel Hygient Important: If fent 27 is merked other that any Injury or other transment. 12 Ballet Teacher Dance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be UNK Sally 2 Harris 19a. informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Howard T. Schlesinger, Jr./son 5925 Robindale Rd. Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory, Inc. 3/17/97 Baltimore, MD 21. Signature of Funeral Service Licenson 22. Name and Address of Facility Cremation Society of Maryland, Inc. Gorge E. MacNabb

299 Frederick Rd. Baltimore, MD 21228
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onsef and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In deeth) **Examiner** Due to (or as a consequence of) Examiner buriel-transit The lew requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Last pue Due to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medical the Due to (or es a consequence of) ettending p Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yas 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings evailable prior to Completed 24a. Was en eutopsy performed? completion of cause of deeth? cate hes 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate Vital ilcian: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manper of Deeth 1 W Natural 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Piaca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide To the Hospital o within 24 hours at To the Funeral Dicompletely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 17, 1997

State Registrar

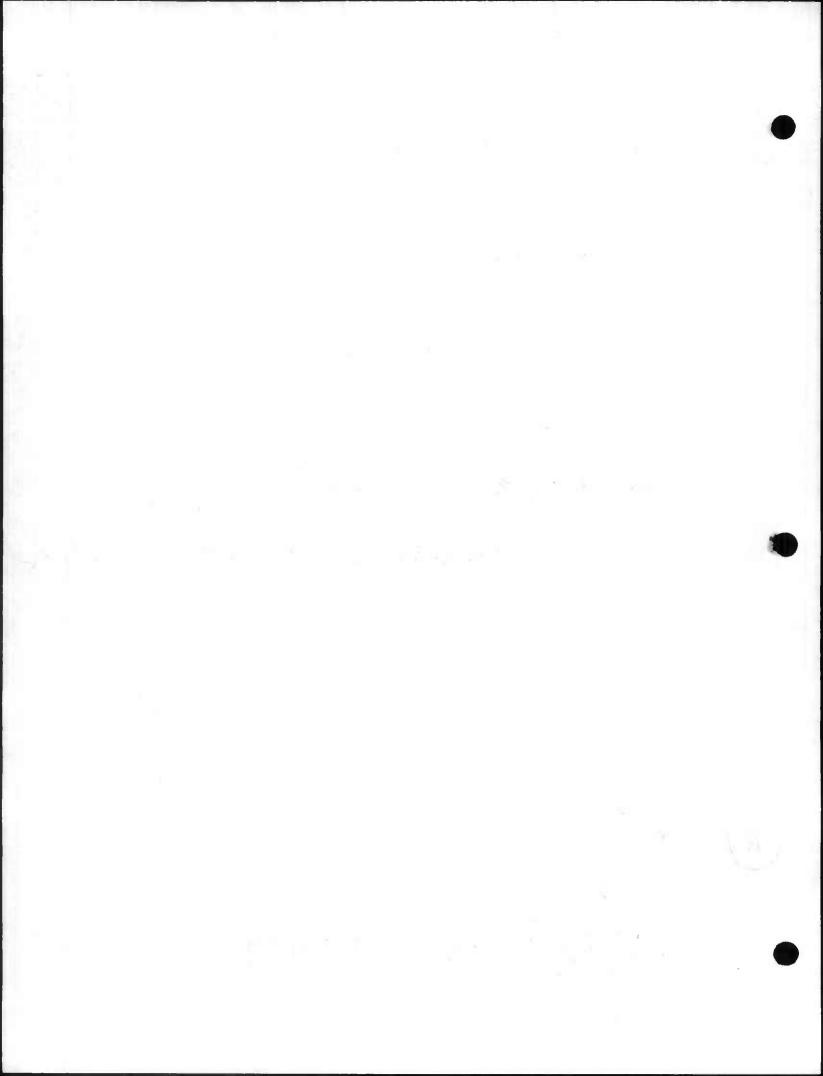
MAR 18 1997

30. Name and addi

31. Date filed (Month, Day, Year)

Ira H. Copeland, M.D. 5310 Old Court Rd., Suite 201 Randallstown, MD 21133 32. Registrar's Signature

person will o completed cause of death (Item 23e) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Item: 8 per F.H. G-745 3/26/97 reb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MUR SC0 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth BAIT more If Under 24 Hrs. 8. Dete of E Decours Age (In vis. lest birthday) 5. Sociel Security Number If Under 1 Year 8. Dete of Birth (Month, Dey, July 14, 6. Sex 1 M 2 F Months Days Min 213-20-6333 Usuai Residence of Decadent Yrs. 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 116 C 12. Was Decedent Ev Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates: 13. Was Decedent of Hispartic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Race - American Indian Black, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Etementary/Secendary (0-12) College (1-4or 5+) 0450 1111 17. Father's Name (First, Middle, Last) 18. Md her's Name (First, Middle, Maiden Sumeme) 20 Sister 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address 7/115. TILLON 3 Pate 20b. Plece of Dispositi 20a. Method of Disposition 1 Buriat 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21 Speature of Funeral Service Licansee Name 05 2222 W, North Ave. the duniase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediete Ceuse (Finat disease or condition resulting in deeth) RELATED TO TIR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequenca of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 Q No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to 24a. Was an autopsy performed? completion of cause of deeth? 1 Yes ≸□ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one)

To the Mospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Fuperal Director: After this certificate has been signed by the attending physician and compless' filled in by the funerel director, page 2 should be detached for use as the buriel-trensit P.O. Box 68760. Records, Division of Vital

Be Completed by Medical Certification: To

State

Physician/Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ò death with

'natural', or items 23s

Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

pemit. Peges 1 end 2 should be filed within Department of Health end Mentel Hygiene. Important: if item 27 is marked other than 'any injury or other treumatic event, tre Me any injury or other treumatic event, tre Me Once.

Physician

/Medicai Examiner

Baltimore, Maryland 21215-0020

the Medical Examiner must be notified at

Director

by

Completed

Be L_o

the Maryland

27. Manner of Death 5 Pending Investigation 2 Accident 4 Homicide

1 Yes 2 No

Naturat

3 Suicide

29a. Certifier

6 Could not be determined

↑ Inpatient 2 ER/Outpatient 3 DOA

1 Yes 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28b. Time of

Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certif

29c. License number

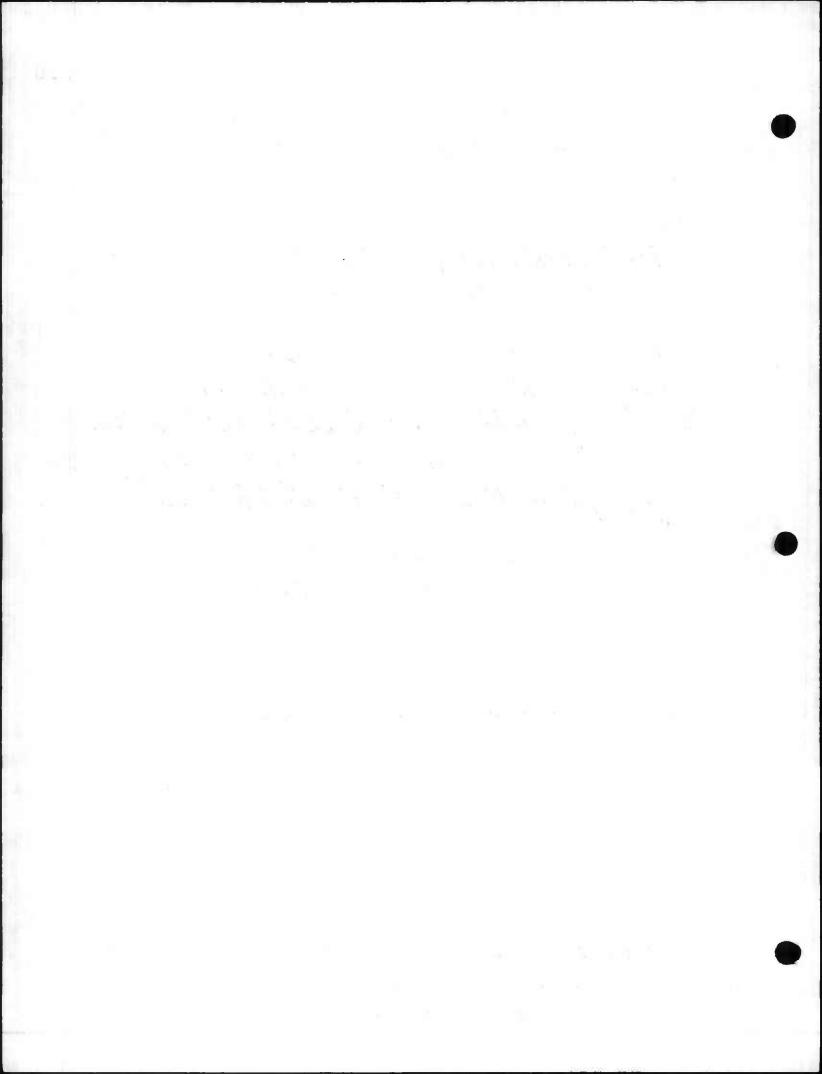
28c. Injury at Work?

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) LIKTISEDAUN SEC

31. Date filed (Month, Day, Yeer) 32. Registrar's Signature

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Data of Death Month DONALD STRAN March 01.30 m 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore 7. Aga (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) January 24, 1930 Maryland 5. Social Security Number 6. Sex 12M 20 F 216-28-4931 Usual Rasidance of Decedant 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 20No Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 21043 U.S.A. 4276 Coattail Court 12. Was Decedent Evar in U,S. Armed Forces? 1 ⊡Yas 2 □ No if Yas, Giva Yeer or Dates: Wes Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indien, Bleck, Whita, atc. 11. Marital Status 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Merchant Shipping Longshoreman 17. Fether's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Surnama) Calvin Stran May Phelps 19a. Intormant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1432 N. Rolling Road Catonsville, Maryland 21228 Deborah S. Scherr (Daughter) 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from Stete
4 Donation 5 Othar (Specify) Woodlawn Cemetery March 18,1997 Woodlawn, Maryland 21. Signeture of Funaral Service Licansee 22. Name end Address of Fecilit Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, Maryland 21228 Lemmer 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset end Death Squamous cell cardnoma of lleng Immediata Causa (Finai monil as disaase or condition rasulting in death) Sequantially list conditions, if any, leading to immediata cause. Entar Undarlying Causa (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Pres 2 No 3 Probably 4 Unknown 24b. Wara eutopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? 1□ Yas 2 No 1 Yes aPNo 25. Was casa retarred to medical 28. Placa of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

à

Completed

Funeral

Director

rthan "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

filed within 72 hours efter Hygiene. Other than "natural", or ite

permit. Pages 1 and 2 should be filed. Department of Health and Mentel Hygie Important: If Nem 27 is marked other 1 any Injury or other traumatic event. In

Baltimore, Maryland 21215-0020

the Maryland

Physician/Medical Examiner

requires that the death certificate be executed attending physician and for use as the burial-tran Records, P.O. Box 68760. Division of

To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After it completely filled in by the funera

þ Be Completed 2 Certification:

1 Yas 2 No 27. Mannar of Beath 14 Natural 2 Accident 3 ☐ Suicide 4 Homicida 29a. Cartifier edical

Registrar

(Check only one)

29b. Signeture end title of contifier

5 Pending invastigetion

6 Could not be

29c. License number

28c. Injury at Work?

1 Yas 2 No

Crtifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and mannar stated. 044701

29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

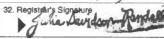
28d. Dascribe how injury occurred

30. Nema and address of person who completed causa of death (Itam 23a) (Type, Print) PAIRACH PINTA VURN, MO

28a. Date of Injury (Month, Day Year)

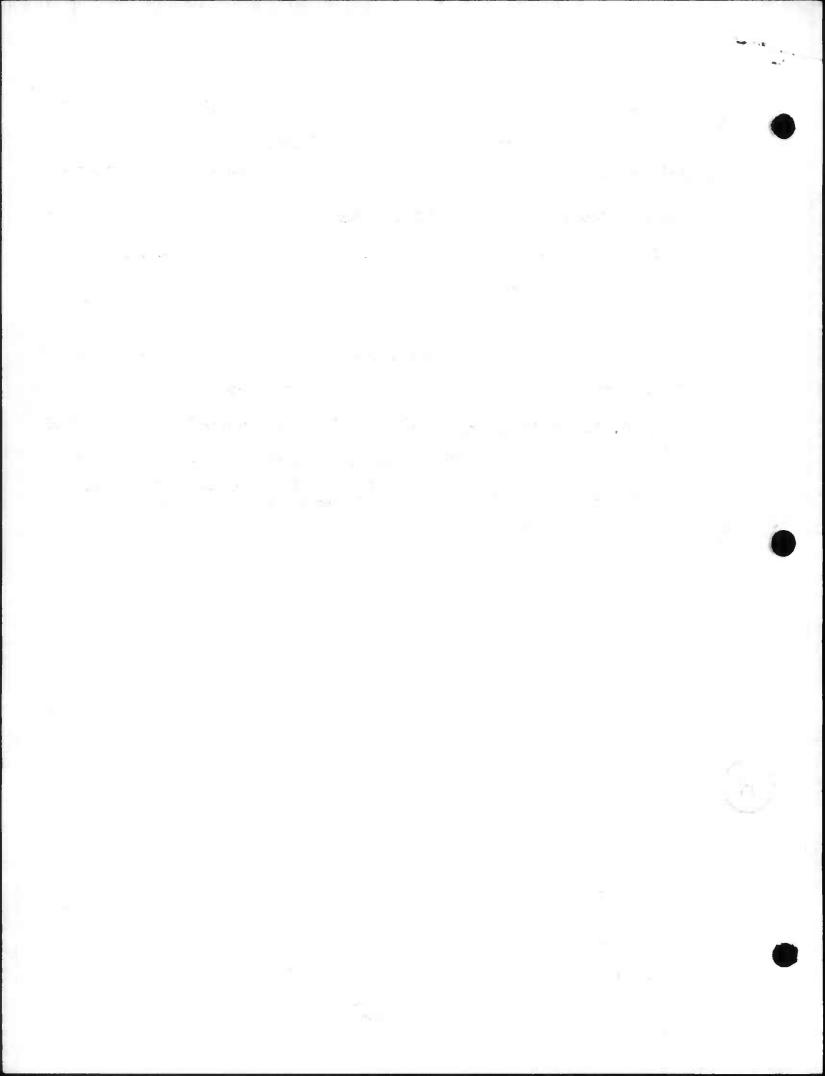
31. Data tiled (Month, Day, Year)

MAR 18 1997



28b. Tima of

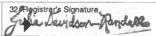
28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Death 9 7 Year **Physician** Arlie Gwen Sikie March 17:55Hrs /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 405 Northfields Ct Edgewood Harford If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1 M XX F Months Deys 211-54-2072 81 Yrs Director 10-29-1915 PENNSYLVANIA Usual Residence of Decedent with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show PA. CAMBRIA PATTON Director XXYes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 202 KINKAID AVENUE 16668 U.S.A. Peges 1 and 2 should be filed within 72 hours after death a nent of health and Mental Hygiere.
Instit if tem 27 is marked other than "natural", or itema 23 and other traumatic event, the Mental Execution from the Funeral 12. Wes Decedent Ever In U,S. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 14. Reca - American Indian, Armed Forces?

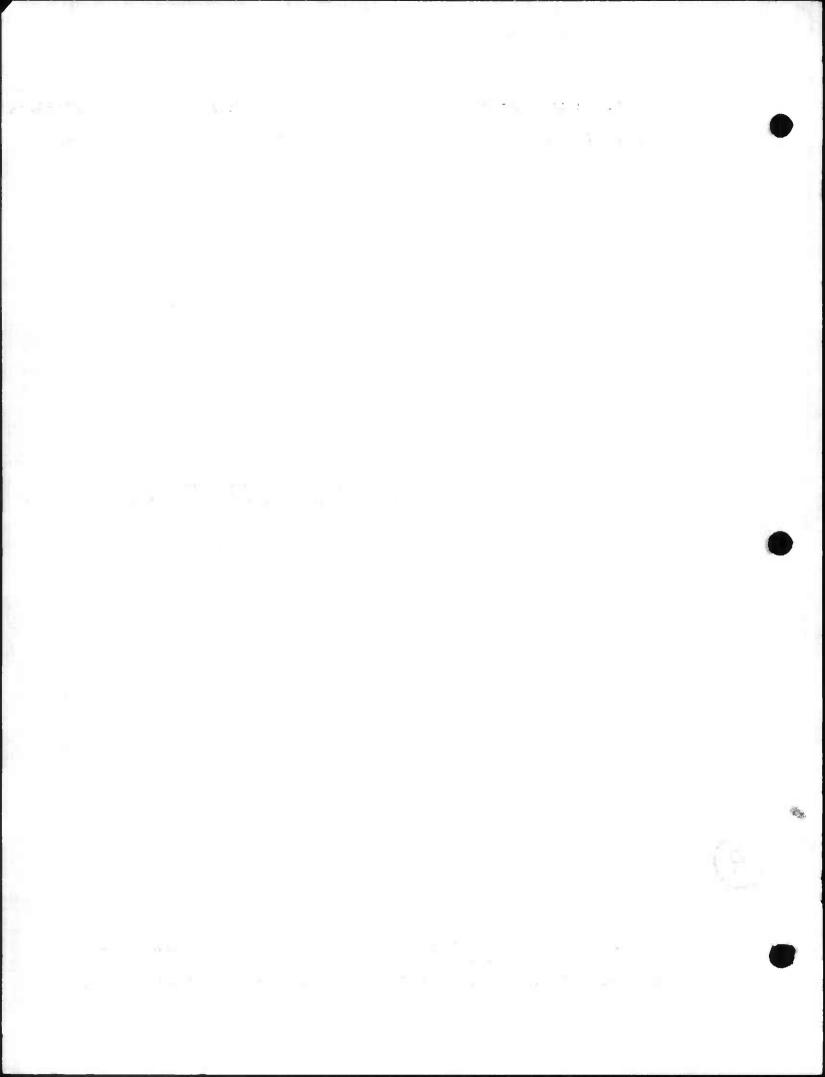
1 ☐ Yes X2 No
If Yes, Give
Yeer or Dates: Black, White, etc. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: WHITE X3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER YEARS OWN HOME 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be WILLIAM BRADFORD VIOLA (UNKNOWN) 2 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 405 NORTHFIELDS CT., EDGEWOOD, MARYLAND, 21040 **JERRY** SIKIE (SON) 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Dieposition Dete 20c. Location - City or Town, State permit. Peges
Department of
Important: If it
any injury or o XXBurlal 2 Cremetion 3 Removel from State FAIRVIEW CEMETERY 3+16-97 PATTON, PENNSYLVANIA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses HENRY W. JENKINS AND SONS COMPANY 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** Acute Coronary Artery Disease /Medical Immediate Ceuse (Finel diseese or condition resulting in death) Examiner Due to (or as a consequence of): Examiner ASCVD physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of): 88 attanding 980 ò signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Hypertension 1 Yes 2 No 3 Probably 4 Unknown Records. à Diabetes Mellitus 24a. Was en autopsy performed? 24b. Were autopsy findings eveilable prior to completion of cause of deeth? Completed certificate 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Was case referred to medical Be 26. Place of Deeth (Check only one) examiner? Other: 4 ☐ Nursing Home 5 🛱 Residence 8 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Mapner of Death Certification: 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Division 1 Netural 5 Pending 1 Tyes 2 No investigation NA 2 Accident NA NA6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Sulcide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) N Δ 4 Homicide NA 29e. Certifier Medical 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pieca, and due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end manner stated. 2 To the within 2 To the comple 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) mm DME D21809 Mar 12th 1997

State Registrar 31. Dete filed (Month, Dey, Year) MAR 1.8 1997



102 Fallston MD 21047 410-879-6564

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) G.S.Prabhu M.D. 1810 Belair Rd #



21	- "	Item: 1 per Physician 1. Decedant's Neme (First, Middle,		/97 reb	Cei	tificate of	Death	2. Data of De		91	3. Time of Death	
Physici /Medio		JANE	ELIZABI	ETH JAN	E SA	FCHUCK		MARCH	Ĩ3,	1997	7:35 E	
Examir		4a. Fecility Name (If not institution,					4b. City, Town, or L	ocation of Deeth	4c. County	of Deeth		
		SAINT JOSE			NTER		TOWSON, N				MORE	
Funeral Director		5. Sociel Sacurity Number 215–30–5747 Usuel Rasidence of Decedent	.Sax 7 1□M 2⊠F	. Age (In yrs. les	Vre	Months Days		8. Dete of Birt (Month, Da Feb. 1	h y, Year) 9, 1934	9. Birthol Count Ma	ece (Stete or Fore try) ryland	
ahow		10a. State 10b. County		10c. City,	Town or Lo	cation				10	Od. Inside City Lim	
8a-fa	Director	Md. Balti	more	T	owson						1 ☐ Yes 2 🔀	
natural', or items 23s or 28s-f show dies Examiner must be nutried at	Dire	10e. Street end Number				10f. Zip Code			10g. Citizen of		try?	
me 23	Funeral	959 Radcliffe R	oad 12. Was Deced	ent Evar in U.S.	13. V	21204		necify Yes or No	U.S.A. or No- 14. Raca - American Indi			
al', or iter	by Fur	1 Never Merried 2 Marrie 3 Widowed 4 Divorced	Armed Force 1 Yes 2 If Yes, Give Yaar or Det	₩ No		Yes, specify Cub ☐ Yas 2 No	Hispenic Origin? (Spen, Mexican, Puerto Specify:	Rican, atc.)	Special	ck, Whita, a		
. 59	Completed	15. Decedent's (Specify only highast Elemantary/Secondary (0-12)			(Give	ent's Usuel Occu kind of work done OO NOT use retire	during most of work	king	16b. Kind of B	Business/Industry		
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le do	o Be	17. Fether's Name (First, Middle, La					18. Mother's Nem	e (First, Middle,		ne)		
h and Mentel 7 Is marked of traumetic even	To	Martin J. Kelly 19a. informent's Name/Reletionship			19b. Mailin	g Address (Street	end Number or Rui			Stete, Zip	Code)	
57.5		Patricia Safchu	ck/Daught			adcliffe		wson, M		21204		
0 -		20e. Method of Disposition	□Ramovel from St	0.000	a of Dispos etery, crem	sition (Neme of natory or other ple	ce)	Date	20c. Location	- City or To	wn, Stete	
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Department of Important: If any injury or once.	Ų,	21. Signeture of Funerel Sarvice Licensee 22. Neme end Addrass of Facility Ruck Towson Funeral 1050 York Road Towson, Maryland 21:										
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physician and s the bunal-transit		Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disaase or injury	G.									
0 0	Medical	thet initieted events resulting In death) Last	C .	Due to (or as	s a consequ	ience of):						
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ched	ysic	Part II. Other significant conditions	contributing to deat	th but not resulting	ng in tha un	derlying cause gi	van in Part I.	23b. Did 1	23b. Did tobacco use contribute to the cause of de			
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s been s 2 should	Completed								en autopsy med?	ava	re eutopsy finding llabla prior to apletion of cause laath?	
pag	Com							101	as 2 No	1 🗆	Yes Z No	
is certificate director, pag	Be	25. Wes case referred to medical exeminer?	Hospitel: X.			041	26. Place of Deel					
Funers arter death. Funeral Director: After this detely filled in by the funeral director.	tlon: To	1 Yes 2 No 27. Manner of Deeth 1 Neturel 5 Pending 2 Accident Investiget	28a. Date of (Month,	Comparison Com)	
i Director	Certification:	3 Sulcida 6 Could not determine	d 28e. Piece of							end Number or Rural Route Number, lete)		
within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the beaminer: On the basi	s of axamination	dga, daath end/or inv	occurred et the til estigation, in my o	ma, data and pleca, opinion, deeth occur	end due to tha ored at the time,	causa(s) and madate and piece,	anner as ste end dua to	eted. tha causa(s)	
within 24 To the Fu	X	29b. Signatura and titla of certifier	D ,	1		29c. Licens			29d. Dete signe	d (Month, E	Day, Year)	
2		> Zinin	1 me	lte m	0.		D41410	1	marel	4 13	1997	
7		30. Name and address of person what JOGINDER P.					ROAD, TO	WSON,	MARYL	AND	21204	
Stat	te ar	31. Data filed (Month, Day, Year) MAR 18 199	32. Reg	Istrar's Signeture	Rande	82						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08164 Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death TUCKER Month SHIRLEY MARCH 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give streat end number) HOSPITAL CENTER RANDALLSTOWN NORTHWEST BALTIMORE 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplaca (State or Foreign Country) 1 M 2 X F 53 212-42-7593 May 20, 1943 MD Usual Residence of Daceden 10a State 10h County 10c. City. Town or Location 10d. inside City Limits 1 Yas 20XNo MD Baltimore Co. Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 215 Northway Rd. 21136 USA 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 10 No If Yes, Give Yaar or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Maritai Status 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 XMarried 1 Yes 2℃No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest greda completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Coilege (1-4or 5+) Bookkeeper 12 Auto Supply Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Edward Smith Jessie Filmore 19a. fnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 215 Northway Rd, Reisterstown, MD 21136 Lindsay K. Tucker, Jr./husband 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2XXCremation 3 ☐ Removal from State Carroll Cremation 3/14/97 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility 21. Signature of Funaral Service Licensee 11824 Reisterstown Rd Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. Approximata Interval Between Onset and Death RESPIRATORY PAILURE Immediate Cause (Final disaasa or condition resulting in death) Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Diseasa or injury that initiated events rasulting in death) Last Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Dfd tobacco usa contribute to the cause of deeth? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 1 No 1 Yes Z No 25. Was case raferred to medical 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) Hospital: 1 inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 Naturaf 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Sulcide 28f. Location (Streat and Number or Rurel Route Number, City or Town, Stete)

physician and s the bunal-transit The law requires that the daath certificata be axecuted Vital Records, P.O. Box 68760, d for use as signed by the all

Physician

/Medical

Examiner

Director

A

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic avent, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mantai Hygiene. Important: if Item 27 is marked other than "natural", or item any Injury or other traumatic avent, the Medical Exercises once.

Physician

/Medical

Examiner

altimore, Maryland 21215-0020

death with the Maryland

Physician/Medicai ð Completed Be 2 Certification:

4 T Homicida

(Check only one)

29a. Cartifian

Hospital of

To the Hospital within 24 hours a To the Funeral C completaly filled

Registrar

State

Medicai

29b. Signatura and title of cartifier

29c. Licansa number D37333

1 Cortifying Physician: To the best of my knowledga, daath occurred at the tima, data and place, and dua to tha causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Yaer) MARCH 14,1997

30. Name and addrass of person who complated cause of death (itam 23a) (Type, Print)

RAVIMO, NHC, BALTO. MOZII33

28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

31. Date filed (Month, Dey, Yeer) MAR 18 1997

32. Registrar's Signature gura Davidson-Randalle

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month THORNTON MARCH JOHN /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BALTIMORE LOSPITAL INAT N/A| If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth | 9. Birthplece (Ste Months | Deys | Hours | Min. | June 14, 1909 | Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. iest birthdey) 9. Birthpiece (State or Foreign 1♥M 2□F 87 Yrs 215-09-0943 Usual Residence of Decedent 10e Stete 10b. County 10c. Cify, Town or Location 10d. inside City Limits MD Yes 2□No Director N/ABaltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5900 Park Heights Ave. Apt. 106 21215 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Yes 2 No if Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2 Ho Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 18b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Engineer Housing Authority 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Jack Thornton Pearl "Unknown" 19e. informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Serena G. Mills-Thornton/Wife 5900 Park Heights Ave., Apt. 106 Balto., MD21215 20e. Method of Disposition 20b. Placa of Disposition (Name of camelery, crametory or other place) Metro Crematory, Inc. 3/14/97 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Cremation Society of Maryland, Inc. 21. Signeture of Europe Serving Licenses M Edward Gregorchik 299 Frederick Rd. Baltimore, MD 21228 23a. Pert1. Enter tha disease, or complications that causad the deeth. Do not enter the mode of dying, such as cardlec or respiretory arrest, shock, or haert fellure. List only one ceuse on each line. Approximete Intervei Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Lest Dua to (or as a consequence of) LRINARY RETENTION Physician/Medicai Due to (or as e consequence of) PROSTATE Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part t. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yas 2 ☐ No LEFT 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24e. Wes an eutopsy 22 No 1 ☐ Yes 2 No 1 Yes 25. Wes case referred to medicai Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Inpatient P 1 Yes 2 ER/Outpetlent 3 DOA 27. Manger of Deeth Dete of injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. injury et Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Records, P.O. Box 68760

g physician and as the burial-tran Division of Vital this

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Medical Examinat must be notified at

other t

Injury or

Physician /Medical

Examiner

permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health end Mental Hygiene. If item 27 is merked other than "natural", or item

Baltimore, Maryland 21215-0020

with the Maryland

death

signed by I been sig funeral ne Hospital or Attending in 24 hours: after death. 4 5

Medical

31. Dete filed (Month, Dey, Year) State Registrar

MAR 18 1997

6 Could not be datermined

3 Suicide

29e. Cartifier

4 Homicide

29b. Signature and 1962 of certifier

28e. Placa of Injury - At homa, farm, streat, fectory, offica building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occurred et the time, data and place, and due to the cause(s) and menner es stated.

[2 Medicaf Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated.

HOSPITAL OF BALTIMORE

29c. License number ASZ40Z3Z1EC 9005 MO

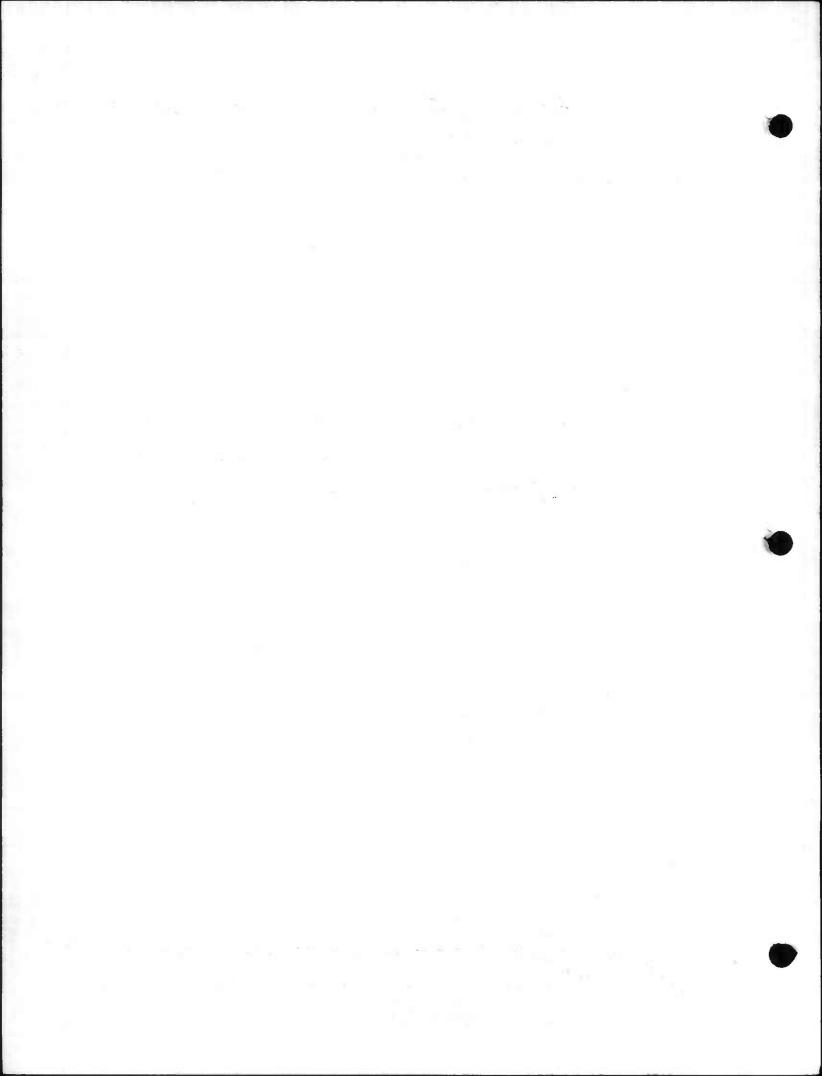
29d. Dete signed (Month, Dey, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

mand eddrass of parson the completed causa of death (Itam 23a) (Type, Print) SINM ARSC MO

32. Registrer's Signeture

Die Devidson

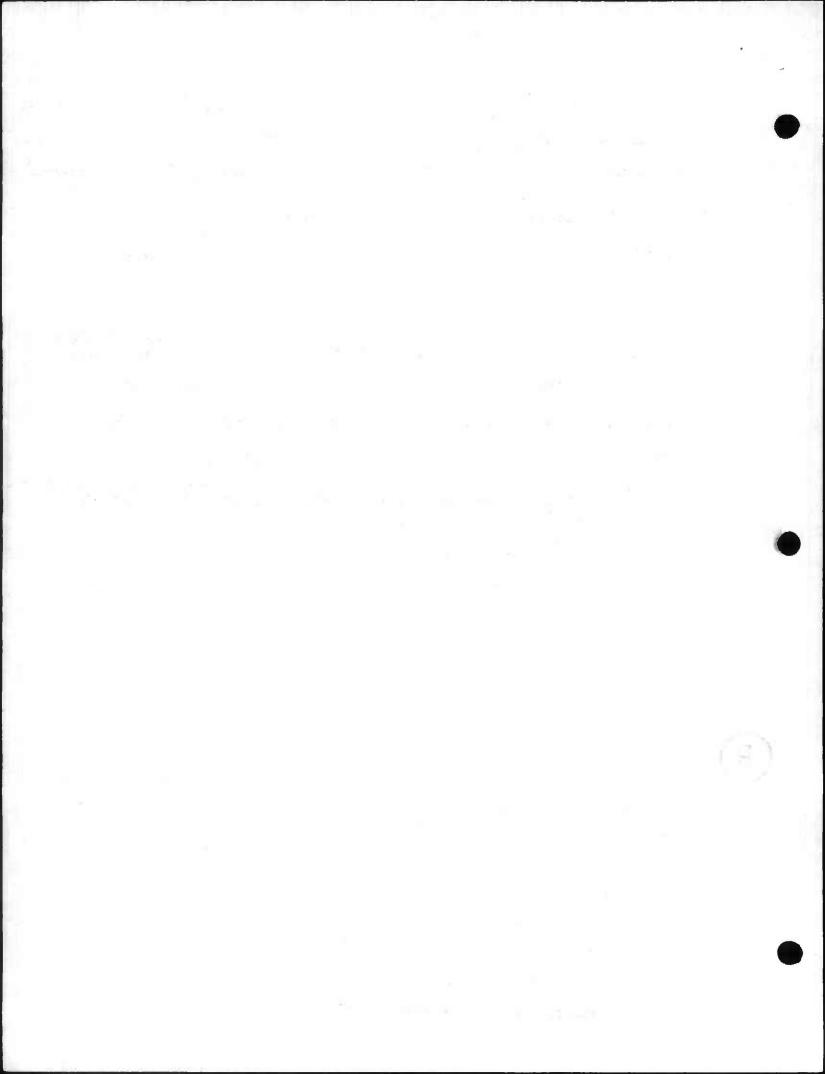


State of Maryland / Department of Health and Mental Hygiene

08166 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Tim f th 2. Dete of Deeth Month **Physician** Thorstraten 8:15 PM ar Torie 14 March 97 /Medicai 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Baltimore NA St. Agnes Hosptial If Under 24 Hrs. 8. Dete of Birth Hours Min. Month, Day, Year, 1924 5. Social Security Number If Under 1 Year 9. Birthplece (State or Foreign County)
Maryland 7. Age (In yrs. lest birthdey) **Funeral** 1□M 25 F Months Deys 217-18-3884 73 Yrs. Director Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Mexical Examiner, must be notified at 10d. Inside City Limits Baltimore Director MD 1 ☐ Yes 2 ☐ No Catonsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21228 307 Lambeth Road U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give A Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status filed within 72 hours eftar 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 ₩idowed 4 Divorced "natural", Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiane. Western Electric Elementery/Secondary (0-12) College (1-4or 5+) Pay Roll Clerk Phone Company permit. Pages 1 and 2 should be file.
Department of Health and Mantal Hy Important: If them 27 is marked other any Injury or other traumatic event. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surname) Be Henry Gross Marie Schoenfelder 0 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Henry J. thor Straten (Son) 622 Wallerson Road, Catonsville, MD 21228 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Buriel 2 Cremation 3 Removal from State
Donetion 5 Other (Specify) 3/18/1997 Loudon Park Maryland 22. Name end Address of Fecility Witzke Funeral Home of Catonsville 21. Signeture of Funerel Service Licensee 1630 Edmondson Ave, Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heart feilure. List only one cade on each line. Approximate Intervel Between Onset end Deeth Physician /Medical Immediete Ceuse (Final Breast disease or condition resulting in deeth) **Examiner** Examiner SEBSIS that the death certificate be executed attending physician and for use es the buriel-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760 Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? the ed by 3 ☐ Probably 4 🕱 Unknown 1 Yes 2 No Records by 24b. Were eutopsy findings eveileble prior to completion of ceuse of death? Completed 24a. Wes en autopsy performed? 1 Yes 2 No 1 Yes 2€ No Division of Vital To the Hospital or Attending Physician: certifi Be 25. Wes cese referred to medicel examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Nopatient 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury et Work? Medical Certification: 28b. Time of 28d. Describe how Injury occurred After Natural 5 Pending Investigation after death.

Director: Aft
d in by the fur 1 ☐ Yes 2 🗆 No 2 Accident 3 Suiclde 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aff To the Funeral DI completely filled in Certifying Phyeiclen: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end manner stated. 29a. Certifier 29b. Signeture and title of certile 29c. License number 29d. Dete signed (Month, Day, Year) D506071 0 pleted cause of deeth (Item 23e) (Type, Prin 30. Name end eddr ss of person who con Wafer Gramil MD 32. Registrer's Signeture 31. Dete filed (Month, Dav. Year) State MAR 18 1997 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Jack Towles March 17, 1997 4:00am 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 828 Jaydee Ave. Dundalk Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 8. Date of Birth (Month, Dey, Year) 8. Date of Birth (Month, Dey, Year) 8. 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country), MARY LAND 1\\ M 2□ F 69 216-20-3620 Months Yrs. Usuei Rasidence of Decedent 10c. City, Town or Location 10d. Inside City Limits BALTIMORE Dundalk 1 ☐ Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4. S. A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ™ Yes 2 □ No If Yes, Give Year or Dates: 11. Maritel Status Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHI +E 3 ☐ Widowed 4 ☐ Divorced 15. Dacedant's Education 16e. Decedent's Usuel Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OPERATOR FROD. LIFT 18. Mother's Neme (First, Middle, Malden Sumeme) 17. Fether's Nama (First, Middle, Last) ROBERT TOWLES 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) SADIE TOWLES 828 JAYDEE BACTO. -WIFE AUC. 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from Stete OAK LAUN Cemeren 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Facility Connel (Y 21. Signature of Funerel Service Licensee FUNERAL HOME of Dundalk 23e. Pert1. Enter the disease, of complications that caused the death D not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilura. List only one cause on each line. Rd. BALD. MO 2/292 Approximete Interval Betweend Onset and De Immediate Ceusa (Final diseese or condition resulting in daath) anknown Sequentielly list conditions, if eny, laading to immadiate cause. Enter Underlying Ceuse (Diseese or Injury that initiated evants resulting in death) Lest Dua to (or es e consequence of): Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown artery disease Corondry 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☑ No

Physician /Medical **Examiner**

permit. Pages 1 and 2:
Department of Health es
Important: If Item 27 Is
any Injury or other tree

Physician

/Medical

Examiner

Funeral

Director

or items 23a or 28a-f show

Directo

Funeral

by

Completed

Be

2

event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite

Baltimore, Maryland 21215-0020

death with the Maryland

attending physician of for use as the bunal signed b has

Records, P.O. Box 68760,

Examiner The law requires that the death certificate be executed Physician/Medical ģ Be Completed P Certification:

within 24 hours after To the Funeral Direc completely filled in by To the Hospital

State

Registrar

Medical

25. Wes case referred to medical 26. Place of Deeth (Check only one) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Tesidence 8 Other (Specify) 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Sulcide Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

29b. Signeture end title of certifier Edward Fancani 29c. License number

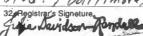
29d. Date signed (Month, Dey, Year)

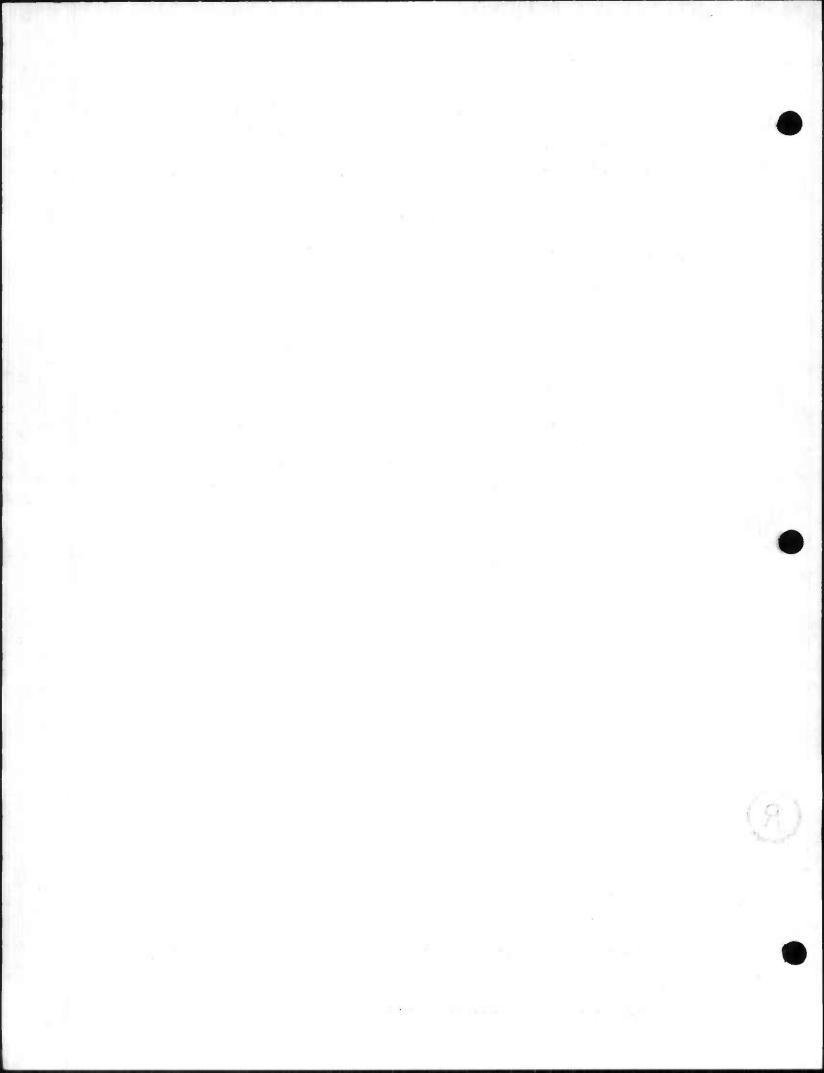
30. Nema end eddress of person who completed causa of deeth (Item 23a) (Type, Print)

Blvd., Baltimore, MP 1005 North Point

31. Dete filed (Month, Day, Year)

MAR 18 1997





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death b Per PHY FilmG745 3-18-97 ria 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 0643 ALLEN TOSTEN March 4e. Fecility Nema (If not institution, giva street and number) 4b. City. Town, or Location of Death Washington Co. Hosp. Hagerstown Washington 6. Sex 1 M 2 □ F 7. Aga (In yrs. last birthday) 73 Yrs. If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number 8. Dete of Birth Month, Days Year 1923 9. Birthplece (State or Foreign PGountry) Deys Hours 217-12-2307 Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits Md. 1 Yes 2 No Washington Clear Spring 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 14103 Fairview Rd. USA 21722 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - American Indien, Biack, Whita, atc. 1 Nevar Merried 2 Married 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Truck Driver Gen. Hauling 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumema) Allen C. Tosten Carrie Rock 19a. In Program of Name Application of the Print and 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 16132 Fairview Rd., Hagerstown, Md. 21740 Mrs. Vonnie Crider 20c. Location - City or Town, State Montgomery Twp., Franklin Co., Pa. 20a. Method of Disposition 20b. Placa of Disposition (Neme of cametery, cremetory or other pleca) 1 Surial 2 Cremetion 3 Removel from State 3/8/97 4 ☐ Donation 5 ☐ Other (Specify) Welsh Run Brethen 21. Signeture of Funeral Senter lies for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intervei Between Onset end Death Immediate Ceuse (Finel disaesa or condition resulting in deeth) ou line Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Due to (or as a consequence of) reunomie Due to (or as e consequence of): (Worman 1 676 818 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 1 No

Physician /Medicai Examiner

Physician

/Medical

Director

Funeral

by

Completed

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Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exampler must be notified at

permit. Peges 1 end 2 should be filed within 7; Department of Health end Mantal Hygiene. Important: If Item 27 is marked other than "na any injury or other traumatic event, the Medic once.

the Maryland

Baltimore, Maryland 21215-0020

burial-transit pue physician e been signed by should be detec certificete

The law requires that the death certificate be axecuted

Records, P.O. Box 68760.

Division of Vital

Physician/Medical Medical Certification: To

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica complately filled in by the funeral director; s

þ Completed Be

25. Was case referred to medical examiner? 27. Manner of Deeth

> 4 Homicide 29a. Certifier

1 PNatural

2 Accident 3 Suicide

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piace, end due to the cause(s) and menner ss steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end pieca, snd due to the cause(s) end menner stated. 29b. Signature and

5 Pending

investigation

8 Could not be determined

MD

28a. Date of Injury (Month, Day Year)

1 Inpatiant 2 ER/Outpatient 3 DOA

28e. Pleca of Injury - At home, farm, straat, factory, office building, etc. (Specify)

28b. Time of

29c. License number

Hag. md.

1 ☐ Yes 2 ☐ No

28c. Injury et Work?

26. Place of Deeth (Check only one)

Othar: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how injury occurred

29d. Data signed (Month, Dey, Year) Norch 5, 1997

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

of person who completed cause of death (Item 23e) (Type, Print)

Hospitei:

31. Dete filed (Month, Dey, Yeer) State MAR 1 8 1997 32 Registrar's Signeture Guna Davidson-Randelle

Registrar

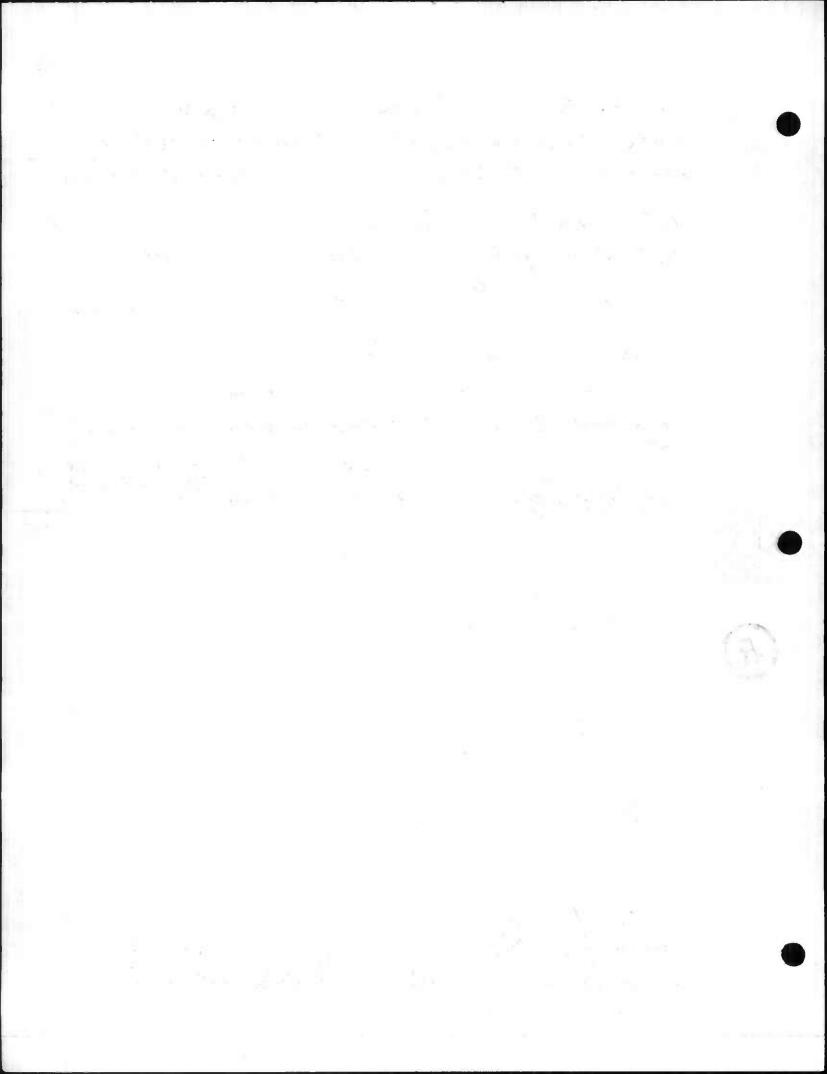
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene.

				State of Marylar		rtment of F tificate of			giene 9	7 08169
Phy	ysicia	an	1. Decedent's Name (First, Middle, Last)		\ /			2. Dete of De Month		3. Time of Deeth
	ysicii Nedic		Alberta F		Vonc			Warep	16 19	97 3347
Ex	amin	er	4e. Fecility Neme (If not institution, give the ACF FORD MP)	1 11.	106,00		Ab. City, Town, or I		1	
Fun	eral		5. Social Security Number 6. Sec	MORIAL NO.	lest birthday)	If Under 1 Year	If Under 24 Hrs.		9 11101	
Direc			247-34-6532 10	IM 2154 7/	Yrs.	Months Deys	Hours Min.	8. Dete of Bir (Month, De	y, Year)	9. Birthplece (State or Foreign Country) BALLIMO L
pus *	2		Usuel Residence of Decedent 10e. Stete 10b. County	10c Cit	y. Town or Loc	etion				
ith the Marylar or 28a-f show	led at	0	MD Han C	100.01	0 /					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
r 28a	Tool	Director	10e. Street end Number	1	Belei	10f. Zip Code			10g. Citizen of Wi	
th with	N N	aiD	1123 Belcan	up Road		210	17		45,	
after death w	SEC. IN	Funeral		2 Wes Decedent Ever In U. Armed Forces?	,S. 13. W	as Decedent of H	lispenic Orlgin? (Spen, Mexican, Puert	pecify Yes or No	- 14. Rece	American Indien, White, etc.
d 21215-0020 filed within 72 hours effer death with the Maryland bygiene. ther than "natural", or Herns 23a or 28a-f show	event, the Medical Examiner must be notified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorcad	1 Yes 2 No If Yes, Give Yeer or Dates:		☐ Yes 2☐ No			Specify:	01.11
21215-0020 d within 72 hours af piene. r than "natural", or	3 63	ped 1	15. Decadent's Educ	cation	16e. Decede	ent's Usuel Occup	etion		16b. Kind of Bus	13/ack
within 7 ene.	Med	Completed	(Specify only highest grede Elementery/Secondary (0-12)	completed) College (1-4or 5+)	(Give k life. D	ind of work done O NOT use retired	etion during most of word d)	king		
d 212 filed with Hygiene. ther ther	7,		UNK	NA		UNIZ			UN	
E Sala	900	Be	17. Fether's Neme (First, Middle, Last)				18. Mother's Nen	ne (First, Middle,	Maiden Sumeme,	
larylan 2 should be end Mental s marked o	treumatic	ဥ	19a. Informent's Name/Relationship (Ty)	ne Print)	19h Mailing	Address (Street	end Number or Ru	NO Poura Numb	or City or Town S	Into Zin Code)
► 5= F.			Storon Floyd -	-wardian	300 M	Motor P	1/12/ 18	2 . 1	e unD.	7 17-11-
or Health	r other		20e. Method of Disposition 1 Burial 2 Cremetion 3 Re		Pleca of Disposi	ition (Neme of story or other plea	(8)	Dete		Ity or Town, Stete
Pages ment of	Injury or		4 Donetion 5 Other (Specify)	emovel from Stete	mut.	ZION	/	3-18-97	Lansel	we mo
Baltimore, permit. Pages 1 er Department of Hear Important: If Itam.	any in		21. Signeture of Funerel Service Licenum	7	22.	Neme end Addre	ss of Fecility	6	38 N. G	theor Street
- 402			11111111	1/2	A	bert P. U	Yhic 7/A	LPA 1	Ba Murre	MD. 21217
Dharata			23 Pert1. Enter the se, or compleshock, or heart feilure. List only of	fions that caused the deeth cause on each line.	n. Do not enter	the mode of dyln	g, such es cerdiac	or respiretory a	rrest,	Approximete Intervel Between Onset end Deeth
Physic /Medi	_		Immediate Cause (Final	damaga	0 1	2				Criser end Deeth
Exami			disease or condition resulting in deeth)	Due to To	U Tonsequ	ence di):	sless			14ear
2 1	25	Examiner	- 1	diatel	3	Υ.				Eyear
Becut	al-transit	хад	Sequentially list conditions, if eny, leeding to immediate	Due to (or	r es e consequ	ence of):				
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a P		8	resulting in deeth) Lest	Due to (or	res e conseque	enca ot):				
Š P		Physician/M	d d							
. 0 03	Deu	SICI	Pert II. Other significant conditions cont	ributing to death but not resu	ulting In the und	lerlying cause give	en in Pert I.	23b. Dld 1	lobacco use contr	ibute to the cause of death?
P.O. that the deby the	Detac		Chunco N	eval fu	lins	2		10	Yes 2 No 3	Probably 4 Unknown
Records, P.O. he law requires that the a has been signed by the	90 p	d D		a				24e Wes	en eutopsy	24b. Were autopsy findings
law req	Shock	Completed		4				perfo	rmed?	eveileble prior to completion of cause of death?
FRed	96ad	Ē						10)	res 2/LM6	1 Yes 2 No
Vitai sicien: The certificate frector page	clor.		25. Wes case referred to medical exeminer?				26. Place of Deel			
the signal of th	an direction	2	1 Yes 2 No		ER/Outpetient	3□ DOA Othe	4 🗆 Nursing M	ome 5 Resid	lence 8 Other	(Specify)
Division of Vita to Attending Physician: after death. I Director: After this certific din he the funes laterate.	2	Lon	27. Menner of Deeth Naturel 5 Pending Accident Investigation	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injun Work	/ et <br Yes 2 □ No	28d. Describe h	now Injury occurred	2.
VISION Attending or death. ector: After	200	Ca	3 Suicide 6 Could not be	28e. Pleca of Injury - At ho	me, ferm, stree		165 2 1140	28f. Location (5	Street end Number	or Rural Route Number,
ರ ಕಿಕೆಕೆ	2	Certification	4 Homicide	building, etc. (Specify)			City or Tow		
To the Hospital or within 24 hours afte To the Funeral Director Director of the Funeral Director Director of the Funeral Direc		- 1	29e. Certifler (Check only (C	clan: To the best of my know er: On the basis of examinet	viedge, deeth o	occurred et the tim	ne, dete end pleca,	end due to the	ceuse(s) and menn	er as stated.
To the H within 24 To the F			one)	end menner steted.	ion end/or inve					
5 ½ 5 g	3		29b. Signature/and title of ceptifier			29c. License	- 0		29d. Dete signed (
			30. Name and address of person who con	uplated cause of dooth (from	23a) /Time P	(02)	7 3 39	1	raval	1,1997
		1	LINDA FREIL	CH (0)	Wel	2 Nove	LBelle	in Ma	2/0/1	
	State		31. Dete filed (Month, Day, Year)	32 Registrar's Signet		2			-, 3,,,	
Reg	gistra		MAR 18 1997	Transportation		-				

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3 Time of Death **Physician** Month Dey Year March 13, 1997 Lawrence Walter Vahle 9:15 P.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holly Hill Manor Towson Baltimore 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) **Funeral** 1 → M 2 □ F Months Days Hours Min Director 467-01-5236 86 4-10-1910 Illinois Usual Residence of Decedent with the Mandand 10b. County 10c. City. Town or Location Item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Modical Examinar must be inclined at 10d. Inside City Limits 1 Yes 2 No Director Maryland Baltimore Towson 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 803 Hillen Road 21286 S. A. death 11. Maritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours efter Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or ite any injury or other traumatic event, the Modical Examina 1 Never Merried 2 Married Yes 2 No Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White À 3 ₩idowed 4 Divorced Yeer or Detes: WW11 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 Assby Line Revere Corp. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Fred Vahle 2 Mary Lee 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 803 Hillen Road, Towson, Maryland 21286 Gerald W. Vahle (Son) 20b. Place of Disposition (Name of cometery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Hilltop Service Corp. 3-15-97 Towson, Maryland 21204 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility Ruck Towson Funeral Home, Inc. 5 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. 21204 Approximate interval Between Onaet and Deeth Physician /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner **buriel-trensit** requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury and Due to (or as a consequence of) P.O. Box 68760. the attending physician hed for use as the burie Physician/Medical thet initieted events resulting in deeth) Lest Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No Probably 4 Unknown Records. by ate hes been signated page 2 should b 24b. Were autopsy findings sveilable prior to 24a. Wes en eutopay Completed completion of cause of deeth? The lew certificate hes 1 Yea 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

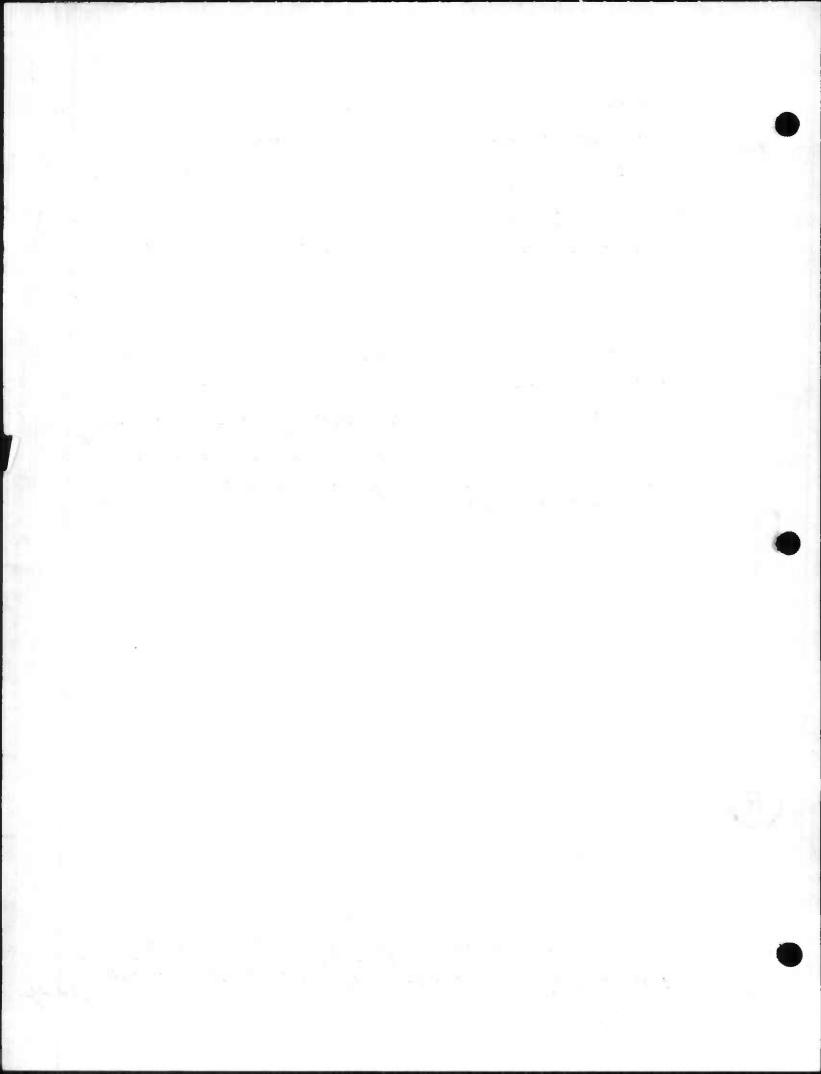
To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Wes case referred to medical Be 28. Place of Death (Check only one) exeminer? Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Certification: 5 Pending Neturel injury 1 ☐ Yes 2 ☐ No € ☐ Accide 6 Could not be determined 3 Sylcide 28e. Place of Injury - A home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 □ Hd micide Medical Certifying Physicisn: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certif (Chec 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signetu and title of 30. Neme end ddress of per pleted cause of deeth (Item 23e) (Type, Print) Leavey, M. D. 7600 Osler Drive, Towson, Maryland 21204 Marc #2- Registraris Signaturanda 31. Dete filed (Month, Day, Year) MAR 18 1997 Registra

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician Month Morch 12,1997 4e. Feolity Name (if not institution, give street end number) Church Home Nursing Center Funeral Director	ate MD
Examiner Ca. Fecility Name (if not institution, give street and number) Church Home Nursing Center Science	ate MD
Comparison Com	ate MD
Usual Residence of Decedent 100. City, Town or Location 101. State 100. City, Town or Location 102. City, Town or Location 103. State 104. Two Baltimore 105. City, Town or Location 106. Street and Number 107. State 108. Street and Number 108. Stre	ate MD
Separation Comparison Com	ate MD
Separation Comparison Com	ate MD
Separation Comparison Com	MD Dayimate
Physician /Medical Examiner Magnetic Ma	MD Dayimate
Physician /Medical Examiner Magnetic Ma	MD
Physician /Medical Examiner Magnetic Ma	MD
Physician /Medical Examiner Magnetic Ma	ximate
Physician Medical Immediate Ceuse (Final disease or condition resulting in death) Sepsis and Dehydration	ximate
b. Heart Failure Due to (or as e consequenca of):	al Between t end Deeth
Cause (Disease or injury thet initiated events resulting in death) Last Organic Brain Syndrome Due to (or as a consequence of):	15
Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.	suce of death?
si = 6.8 A	opsy findings
24a. Was an autopsy performed? 24b. Were auto available completion of deeth? 1 Yes 2 No 1 Yes	in of cause
25. Wes case referred to medical axeminer? 26. Place of Death (Check only one)	
27. Manner of Death 1 Inpatient 2 EHOURDetlent 3 DOA 412 Nursing Home 5 Hesidenca 6 Other (Specify)	Number
4 Homicide building, etc. (Specify) City or Town, State) 29a. Certifier 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.	
one) 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the call and manner stated.	
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) State 31. Date filed (Month, Day, Year) 32. Registrar's Signature (Month)	
State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature AR 18 1997 33. Registrar's Signature	0



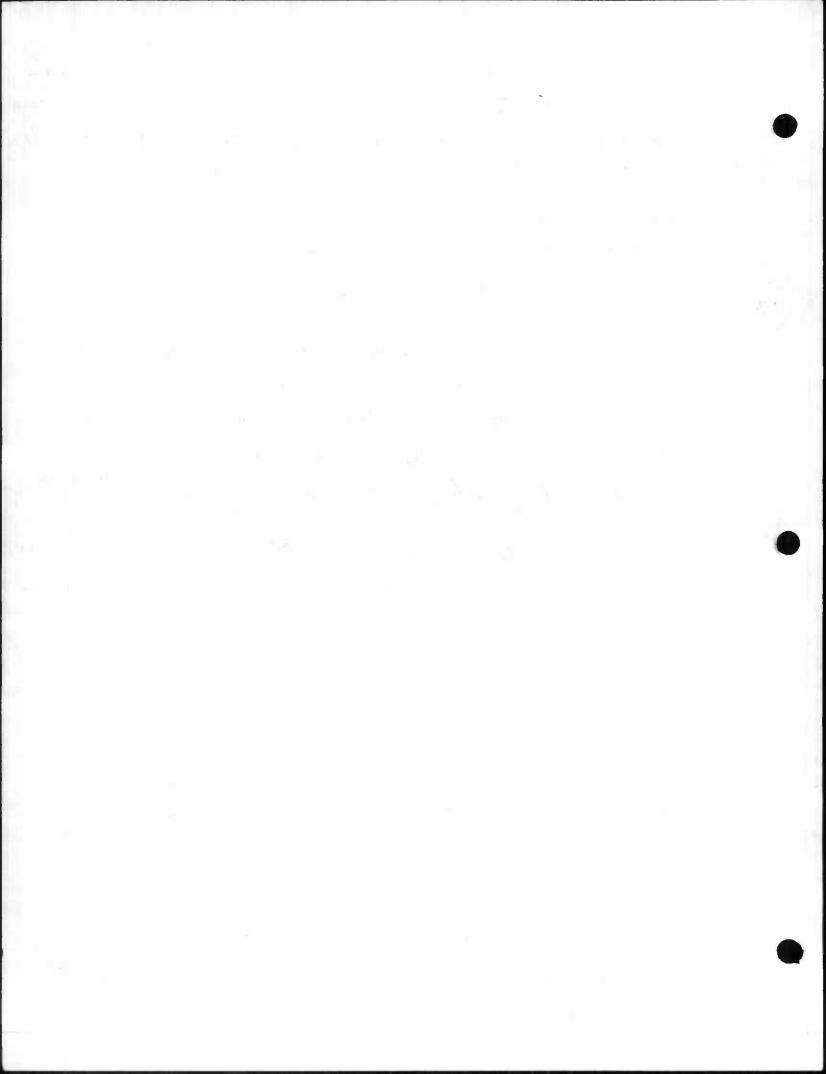
State of Maryland / Department of Health and Mental Hygiene

08172 ITEM# 23b PER PHYNS 3/24/97 FLM#G745 J.A. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death WENGER **Physician** CHRISTINE MARCH 4 31 AM 1674 1997 /Medical 4e. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NORTH ARUNDEL HOSPITAL CLEN BURNE ANNE ARUNDE 5. Social Security Number 7. Aga (In yrs. lest birthday) If Undar 1 Yaar 8. Date of Birth
(Month, Day Year)
June 12,1912 9. Birthplaca (Stete or Foreign **Funeral** Months Deys Hours Virginia 230-14-4030 84 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Max be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Pasadena 10e Street and Number 10f. Zip Code 10g. Citizan of What Country? 23a or 8268 Waterford Road 21122 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No if Yas, Giva Year or Datas: 11 Marital Statue Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decadent's Education (Spacify only highest grade completed) 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore, Maryland 21216 Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator National Plastics 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be 2 should be fi and Mental H is marked off Julia A. Raines Frank Wenger 20 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Arnold L. Wenger 8256 Balto-Annapolis Road, Pasadena, Md. 21122 Department of Health Important: If item 27 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burlal 2 Cremation 3 Removal from State Glen Haven Mem.Park 3-19-97 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addrass of Fecility McCully Funeral Hone of Pasadena 21. Signatura of Fungral Service Lig 3204 Mountain Road, Pasadena, Maryland 21122 the disease, or complications that causad the death. Do not antar the mode of dying, such as cardiac or raspiratory arrast, and failure. List only one cause on each line. Approximata Interval Between Onset and Deeth **Physician** ACUTE INFERIOR WALL MYOCARDIAL /Medical tmmedlete Cause (Final disaasa or condition resulting in death) **Examiner** CARDIOGENIC SHOCK Physician/Medical Examiner requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last nding physician and use es the burial-tran Records, P.O. Box 68760, the Due to (or es e consequence of) for 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 21 No 3 Probably 4 Unknown à Be Completed 24b. Were autopsy findings available prior to 24a. Was an autopsy performad? completion of cause of deeth? 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residenca 6 Othar (Specify) Yes 2 No 2 ER/Outpatient 3□ DOA Certification: To Menner of Death Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Netural 5 Pending Investigation 1 Yes 2 Accident 6 Could not be determined 3 ☐ Sulcide Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. Licansa number MARCH 16TH 1997 301 HOSPITAL DRIVE 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) MORTH ARUNDEL HOSPITAL GLEN BURNIE 21061 JAMES APPIAH-PIPPIM 31. Date filed (Month, Day, Yeer) 32. Registrer's Signature ia Davidson-Randell MAR 1 8 1997 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Ward 1235 March 17 4e. Fecility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Hospital Memorial Baltimore N/A If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yeer 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 20 F Months Deys 430-34-6850 74 Yrs. 14,1922 Virginia Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland N/A Baltimore 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21211 1400 Berry Street USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes ŽONo Specify: Specify: white 3℃Widowed 4 Divorced Yeer or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) John William Higgins Eva Jacks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Cianferano (Daughter) 477 Sumpter Dr. Perryville, MD 21903 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Crest Lawn Mem Grdn 3/20/97 Marriottsville, MD d Funeral Service Li 22. Name end Address of Fecility Burgee-Henss Funeral Home 3631 Falls Road Baltimore, Maryland 2121 23a. Part Enter the distance, or complications that ceused the deeth. Do not enter the mode of dylng, such as cardiac or respiretory errest, Approximate Approximate Interval Between Onset end Death Immediate Ceuse (Final disease or condition resulting In death) cardiomyopathy 4415 Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ailure with severe azotemia 24b. Were autopsy findings available prior to 24e. Was an eulopsy completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical

Physician /Medical Examiner

Examiner

by Physician/Medical

Completed

Be

1 Yes 2 No 27. Manner of Death

1 Naturel

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

Union

Certification: To

Medical

Physician

/Medical

Examiner

10a State

Funeral

Director

or 28a-f show

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by

Be Completed

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"netural", or items 23a or 28a-f shov

pernit. Pages 1 and 2 should be filed within 72 hours after of Depertment of Health end Mental Hygiene. Inforciant: If Itam 27 Is merked other then "natural", or frei any injury or other traumatic event, tre Mexical Examines once.

Baltimore, Maryland 21215-0020

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death v

e law requires that the death certificate be executed the buriel-transit Records, P.O. Box 68760, USB as for has of Wital

death

after death Director: To the Hospital of within 24 hours at To the Funeral Dicompletely filled is

Division

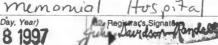
Registrar

31. Date filed (Month, Day, Year) MAR 18 1997

29b. Signature and title of certifier

5 Pending Investigation

6 Could not be determined



Hospital: 106 Inpatient 2 ER/Outpetlent 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

mo

28a. Dele of Injury (Month, Day Year)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

28. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

28c. Injury el Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

pd Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, end due to the ceuse(s) and manner as stated.

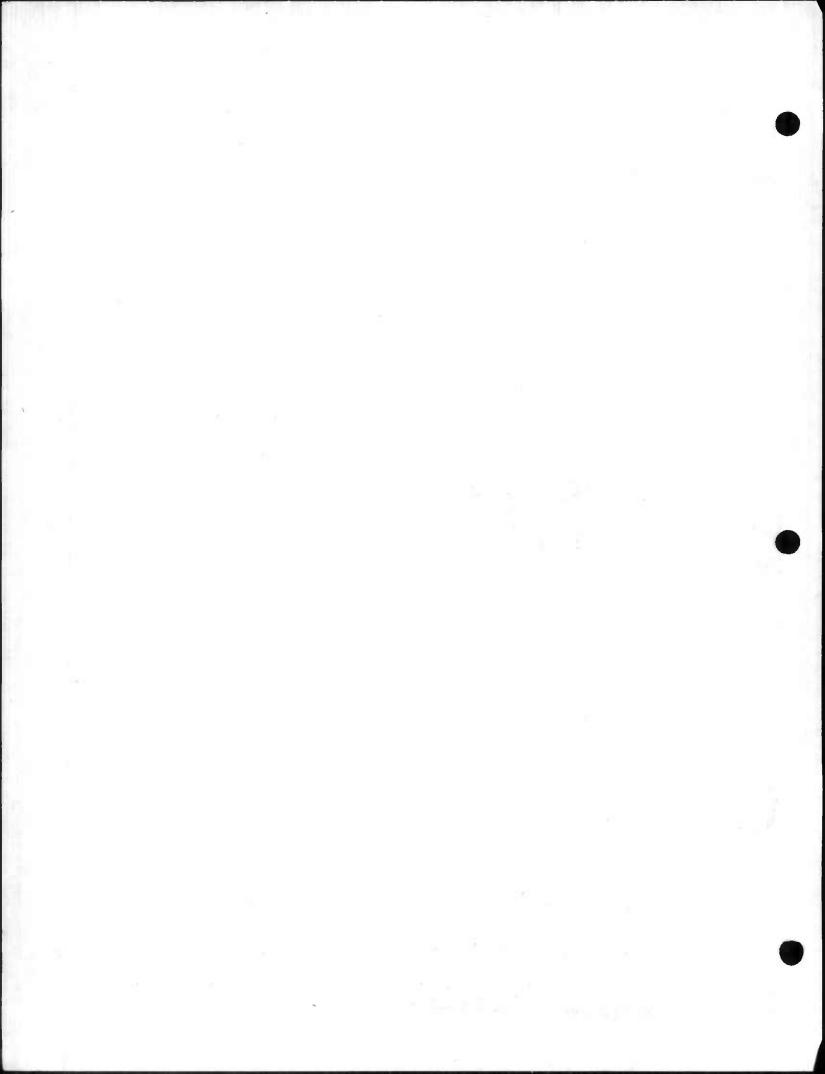
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, end due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

AT 243 8946 march 17, 1997 Baltimore,

mp

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08/74 Item 4b Per FH. Film G745 3-18-97 Certificate of Death rja 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month HELENA : 10 PM WHITE MARCH 4b. City, Town, or Location of Death ELLICOTT CITY
Baltimore 4a. Facility Name (If not institution, give street and number) 4c. County of Death St. Agnes Nursing & Rehabilitation Center HOWARD Months Days Hours Min. April 16,1906 5. Social Sacurity Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foreign 044-26-2153 1 M 2 F Connecticut 90 Yrs. Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits Howard Columbia 1 ☐ Yas 2 No COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5491 Mystic Court 21044 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes ZEVNo 1 Never Married 2 Married 1 Yas 2 No Specify: Specify: White 3 ➡ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Malden Surname) John Donahue Mary (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas F. White, Jr. (Son) 5491 Mystic Court, Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 3/17/97 All Saints Cemetery Connecticut 22. Name and Addrass of Facilit Witzke Funeral Home of Columbia 21. Signature of Funeral Service Licensee 5555 Twin Knolls Road, Columbia, MD 21045 13 23a. Part1. Enter the disease, or complications that ceused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) b Neumon 18 Due to (or as a consequence of): Mulhintant Demention - END STAGE Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

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Pagas 1 and 2 should be filed within 72 hours aftar

Baltimore, Maryland 21215-0020

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e law requires that the death cartificate be axecuted

Box 68760,

Records, P.O.

Division

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Director

Physician/Medical þ Completed Be To the Hospital or At within 24 hours after or To the Funeral Direct complately filled in by filled in by

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last examiner?

Certification: To

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatlant 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Panding Investigation 2 No 6 Could not be determined 3 Suicida 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 4 Homicida

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of pertifier

ATTONG

34868

29c. License number

29d. Date signed (Month, Day, Year) Mancet 14, 1997

PK Columbia, MD 21044

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DIENZA 11055 PATURINA LITTE

State Registrar

Medical

31. Date filed (Month, Day, Year) MAR 1 8 1997

32. Registrar's Signature while Davidson

e see (2.8) years and

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'e Name (First, Middle, Last) 2. Dete of Death Day Month WARGO JOSEPH MARCH 13, 1997 4:07 P 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth THE JOHNS HOPKINS HOSPITAL 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplece (Stete or Foreign ₩ 2□ F Yrs. 67 217-24-3242 Usual Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d. Ineide City Limits 1□Yes 2□No Maryland Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Street 21224 1439 Bonsal U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tayles 2 □ No 1952 − It Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 5'th NA Broom Maker Broom Factory 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Thomas Wargo Mary Lieber 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Wargo 1439 Bonsal Street Baltimore, Maryland21224 Pia (Wife) 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State 1 X Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Gardens of Faith March 17 Baltimore, Maryland 21. Signature of Funeral Service Ligan 22. Name and Address of Fecility W. Dabrowski/Chojnacki F.H. P.A.₂₁₂₂₄ 1005 Dundalk Ave. Baltimore, Maryland thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, on each line. Approximate Interval Between Onset and Deeth Hypotension Immediate Cause (Finel 2 days disease or condition resulting in deeth) Esophageal Varices eeding Due to (or es consequence of): Cirrhosis 5 years Due to (or as a consequence of): 10-20 405 Alcoholism 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | 3 □ Probably 4 □ Unknown none 24b. Were autopsy findings aveileble prior to 24e. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

permit. Page Department of Important: If any Injury or once.

Physician

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Examiner

Funeral

Director

ral', or Items 23a or 28a-f show Examiner mant be notified at

Pages 1 and 2 should be filed within 72 hours after neat of Health and Mertal hygiene. and If it is marked other than "natural", or ite any or other traumatic event, the Merical Energies any or other traumatic event, the Merical Energies.

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21215-0020

Baltimore, Maryland

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Registrar

Examiner Sequentially list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Physician/Medicai Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Be Completed 25. Was cese reterred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA

28e. Date of Injury (Month, Dey Year)

28b. Time of Injury 28c. Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Deeth

1 Netural
2 Accident 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Yes 2 No 28e. Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and menner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Dete signed (Month, Dey, Year)

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32. Redistrar's 9thature

Park Ave.

30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

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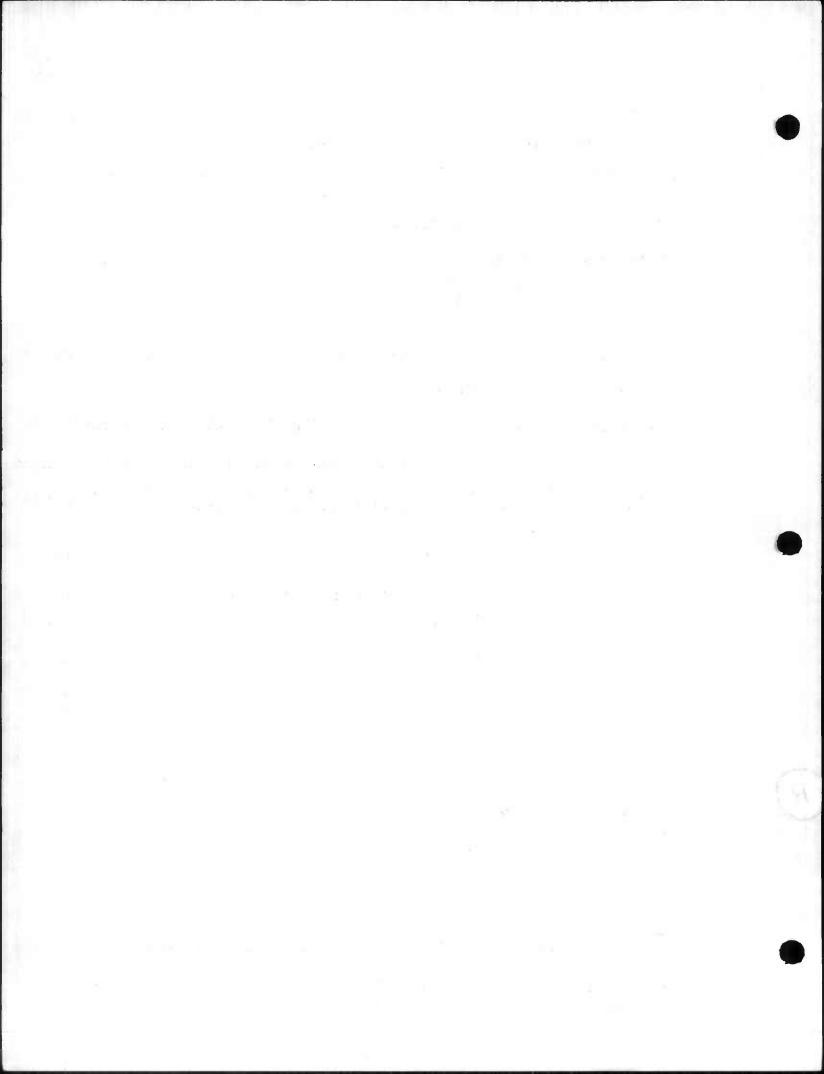
TOM CHANG

31. Date tiled (Month, Day, Yeer) MAR 18 1997

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Apt 405 N; Baltimore, MD 21217

MARCH 13, 1997

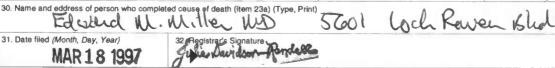


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08176 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** Gertrude White May 3:25 p.m. 13, 1997 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner 3504 Hiss Avenue Parkville Baltimore H Under 1 Year H Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Sept. 7, 1912 5. Social Security Number 7. Age (fn yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛣 F 214-14-9611 Director 84 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County show 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Md. Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3504 HissAvenue 21234 United States death Funeral 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian permit. Pages 1 and 2 should be filed within 72 hours effect Department of Healin and Mental Hyglene.
Important: If Itam 27 is marked other than "natural", or hanny injury or other traument. Bleck, White, etc. I ☐ Yes 2 No If Yes, Give 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 X Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Hooper 2 Williamina Pusey 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) James E. White / Son 1233 Meridene Drive Baltimore, MD 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlal 2 XCremation 3 ☐ Removal from State Hilltop Service Corp. 4 ☐ Donation 5 ☐ Other (Specify) Towson Maryland 3/15/97 21. Signature of Funeral Service Licensee Milton J, Knight Jr 22. Name and Address of Fecility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 aused the beath. Do not enter the mode of dying, such as cerdiac or respiratory errest, 23a. Pert1. Enter the disease of complications the shock, or heart failure. List only one ceus Approximete Intervel Between Onset and Deeth **Physician** immediete Cause (Final disease or condition resulting in death) /Medical curdiomy opa **Examiner** Cardia ascular Direcise Examiner use es the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of) Box 68760. ettending physician certificate be Physician/Medicai Due to (or as a consequence of): ò P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. deteched 23b. Did tobacco use contribute to the cause of deeth? 94 à 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, by 8 24b. Were autopsy findings evailable prior to completion of ceuse of deeth? 24e. Wes en autopsy Completed peen performed? The certificate 2 4 Nio 1 Ves 1 ☐ Yes 2 ☐ No Physician: 25. Was cese referred to medicel examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After ö Bull 1 PNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 critifying Physicien: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) end menner es steted.

| Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. Medicai 29a. Certifier (Check only one 17.0 \$

State Registrar 31. Date filed (Month, Day, Year) MAR 18 1997

29b. Signature and title of certifier



29d. Date signed (Month, Day Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Year Month 8:08 pm white JOANN 14 1997 4a. Facility Name (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY if Under 24 Hrs. 8 Data of 5. Social Sacurity Number If Undar 1 Year 8. Data of Birth (Month, Day, Year) May 17, 1929 West Virginia 6. Sax 7. Age (In yrs. last birthday) 1□M 2☑F Months Days Hours Min. 67 Yrs. 216-28-2024 Usual Rasidence of Decedant 10a Stata 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21214 United States 3035 Weaver Avenue 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 13. Was Decadent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Raca - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Nevar Married 2 Married 1 ☐ Yas 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decadant's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) Accounting Dept. Commercial Credit Company 12 17. Fethar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumame) White Audrey Adams Austin G. 19a. Informant's Name/Ratetionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mr. Robert G. White/Brother 3035 Weaver Avenue Baltimore, Maryland 21214 20a. Mathod of Disposition 20b. Place of Disposition (Nema of camatary, crametory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from State Parkwood Cemetery 3/18/97 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licansee Brian A. Willem 22. Nama and Addrass of Facility Leonard J. Ruck Funeral Home, Inc. 5305 Harrford Road Baltimore, Maryland 21214 23e. Pert1. Enter the disaasa, or compilcations that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ntarval Between Onsat and Deeth Immediate Ceuse (Finat disease or condition rasulting In deeth) ue to (or es a consequance of): Sequentielly list conditlons, if any, leading to Immadiata cause. Enter Underlying Causa (Disaasa or Injury that initiated events rasulting in daath) Last Dua to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 SYee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 No 1 Yes 2 No 25. Was casa refarrad to medicel 26. Placa of Daath (Check only one) Hospital: Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Yaar) 27. Manner of Death

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Physician/Medicai

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Certification:

Medical

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29a. Certifier

2 Accidant

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29b. Signature and titla of cartifiar

30. Name and address of

Physician

/Medical

Examiner

Funeral

Director

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7 is marked other traumatic event,

Department of Important: If any Injury or once.

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21215-0020

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> State Registrar

BEVERLY M. Calkins
31. Data filed (North, Day, Year)

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6 Could not be

32. Registrar's Signatura

erson who completed cause of death (Item 23e) (Type, Print)

M.D.

28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Tas 2 No

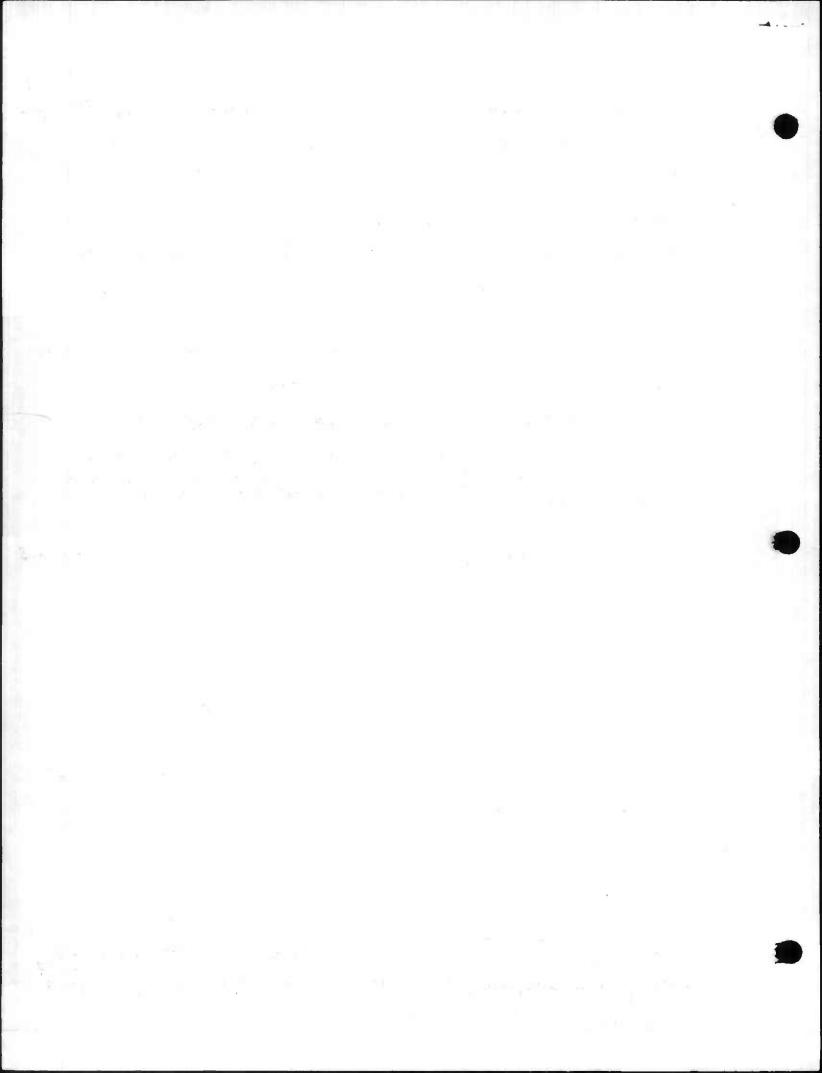
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Location (Street and Number or Rural Routa Number, City or Town, State)

1 🛣 Cartifying Physician: To the best of my knowladge, deeth occurred et the tima, data and place, end due to the ceuse(s) and mannar as stated. 2 Medical Exeminar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. Licensa number 29d. Data signed (Month, Day, Yaar)

600 North Wolfe Street, Bultmane, Maryland

DHMH 16 Bev 6/95



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uc	ding Ph h. After th funeral	ion	27. Menner of Deeth Neturel	5 Pending	28e. Dete of injur (Month, De)		ime of njury M		ryet ork?]Yes 2 □ No	28d. Describe	how injury occurr	red																	
Division of	or Attending Physician: effer deeth. Director: After this certifica in by the funeral director,	ertification:	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be	28e. Plece of init	ırv - At home, fa			162 2 140	28f. Location	28f. Location (Street end Number or Rurel Route Number,																		
2	of or of or	enti	28e. Place of injury - At home, farm, street, fectory, office building, etc. (Specify)								ity or Town, Stete)																		
	To the Hospital of within 24 hours en To the Funeral D completely filled it	cai C	29e. Certifier (Check only	Certifying Phys	ician: To the best of	f my knowledge	, deeth occurr	ed et the ti	me, dete end pl	ece, end due to the	ceuse(s) end me	nner as stet	ed.																
	the Hi in 24 the Fu	edicai	one)	2☐ Medical Examir	end menner ste	ted.	d/or investigati	on, in my	opinion, deeth o	ccurred et the time	, date end piece, e	end due to th	ie ceuse(s)																
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	Registr			0 5 1997	Julia D	or's Signeture	ndelle																						

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State of Maryland / Department of Health and Mental Hygiene

				Oldio of IVI	arylana /	Certificat			Wiemanny	Reg. No.	97	08179		
	Dhyolo	on	1. Decedent's Name (First, Middle, L	ast)					2. Date of De Month		Year	3. Time of Death		
	Physic: /Medi		Mariana			varenga			March		1997	2:55 P.M.		
Ì	Examir	ner	4a. Facility Nama (if not institution, gi	Alterdated Health			41	b. City, Town, or	Location of Deat	h 4c. Count	y of Death			
			348 West Deer P			T KILL	4 1/2 1	Gaither			tgomery			
	Funeral Director			1 □ M 2 ☑ E	ge (In yrs. last b 41	Yrs. Months	r 1 Yaar Days	Hours Min	. (Month, Da	th ly, Year) 6, 1955	9. Birthplac Country Guate	ce (State or Foreign r) mala		
	ytand sow		10a. State 10b. County		10c. City, Tov	vn or Location					100	I. Inside City Limits		
	with the Maryland a or 28a-f show Lbe notified at	ctor	Maryland Montgon	nery	Gaithe	ersburg						1⊠Yes 2□No		
	± 22 €	Director	10e. Street and Number			10f. Zip	Code			10g. Citizen of	What Country	n		
	ath w 23a 3251		348 W. Deer Park				208			United				
21215-0020	d within 72 hours attar death with the Maryar jone I than "natural", or items 23s or 28s-f show than Madical Examiner must be notified at the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 XX If Yes, Giva Year or Dates:		1 ☑ Yes		Specify:	Specify Yas or No nto Rican, etc.)	Speci	ce - American ick, White, etc fy: Whili	c.		
20	72 ho	ted	15. Decedent's E (Specify only highest gi	ducation	168	. Decedent's Usus (Giva kind of wo			dring	16b. Kind of E				
2	within one. then 'r	Completed	Elementary/Secondary (0-12)	College (1-4or		life. DO NOT us	se retired)	unng most of wo	orking					
2	Hygier Other th ent, the	To Be Con	12	43		Housewi				Own He				
and	d off		17. Father's Name (First, Middle, Las						me (First, Middla	2-2-10				
Baltimore, Maryland	should nd Mei merke imetic		Felipe DeJesus R		10	b. Mailing Address	(Street o	Gregor		Cela		la da l		
	00 年度 西		Jose Alvarenga			48 West								
	F Hoa		20a. Method of Disposition	(Husballu)	20b. Placa o	of Disposition (Nar ary, crematory or o	me of		Date Date	20c. Location				
	Pages nent of int: If its ary or o		1 ☑ Burial 2 ☐ Cremation 3 [4 ☐ Donation 5 ☐ Other (Spec			of Heaver			3/6/97	Silver	Spring	, MD		
ä	4 4 4 4 4	۰	21. Signature of Funaral Service Ltd	nsee	Jace (22. Nama an			DeVol F			,, 110		
g	Dept.		Michael	D. Cell	lear	10 Fact	- Doo	r Dark				20877		
· P	Physician		23a. Part1. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death											
d	/Medical Examiner	10	immediate Cause (Final disease or condition a. ADENO CARCIHOMA OF GALBLADDER 5 MO resulting in death)											
			resulting in death)		Due to (or as a	consequence of):								
	nted Insit	edical Examiner		b. ———	_	*					- 1			
Ć.	tificete be executed ig physician and as the bunel-transit	Exa	Sequentially list conditions, if any, laading to Immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events		Due to (or as a	consequence of):								
68760,	ysicia	Ical	Cause (Disease or Injury that initiated events	C	Due to (or as a	consequence of);								
	ng ph	-	resulting In death) Last											
Вох	or use	lan		d							1			
0	the e	Physician/N	Part II. Other significant conditions	contributing to death b	ut not resulting	in the undertying c	ause give	n In Part i.	23b. Did	23b. Did tobacco use contribute to the cause of				
P.0.	requires that tha deeth certi seen signed by the ettending should be detached for use a								10	Yee 32 No	3 Probei	bly 4 Unknown		
g Sp.	w requires to been signer should be	d by							24a Was	an autopsy	24b. Were	autopsy findings		
00	y req	Completed								ormed?	comp	able prior to pletion of ceuse		
æ	S S C	ошо							10	Yes 2⊠ No	of de			
ta		0	25. Was case referred to medical					26 Place of De	ath (Check only		101	Yas 2□ No		
\geq	5 00	OB	examiner? 1 ☐ Yes 2☑ No	Hospitai: 1 ☐ inpatia	ant 2 ER/O	utpatient 3 DC	Otha	p.	Home 5 23 Rasi		har (Specify)			
0	ding Phy. h. After thi funeral	n: T	27. Manner of Death	28a. Date of Inju (Month, Da	ry 28b.		28c. injury Work			how injury occu				
<u> </u>	aath. or: Af	atic	1 Natural 5 Panding 2 Accident Investigation	n	, , , ,	M		es 2 No						
Division of Vital Records,	free di	Certification:	3 ☐ Sulcide 6 ☐ Could not be determined 28e. Placa of injury - At home, farm, street, factory, offica building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	oral o		00-0-48											
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edicai		nysician: To the best on miner: On the basis of manner str	examination ar									
	other vithin ompl	Me	29b. Signature and tiple of certifier	0/1		290	c. License	number		29d. Date signe	ed (Month, Da	ıy, Year)		
	- > - 0		> Stone	Jamet	12		741	205	`	March	4, 199	9.7		
	3		30. Name and address of person who	completed cause of t	eath (Item 23a)		11	700		Hatell	7, 17.	/1		
_)		Steven E. Swartz,	M.D., 111	19 Rock	ville Pi	ke,	#502, Ro	ockville	, Maryl	and 208	852		
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ark Signature	door Randa	00							
	Registr	ar	MAR 0	199/ P	, who wave	ason-Nanae	مالا							

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Frances N. Alexander March 1, 1997 3:55 AM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Rockville If Under 24 Hrs. 4807 Mori Drive Montgomery If Undar 1 Yaar 5. Sociel Security Numbar 7. Aga (In yrs. last birthdey) Birthplece (State or Foreign Country) 8. Data of Birth (Month, Dey, Year) Funeral Deys Hours 1 □ M 2 1 F Months Min. Director 579-32-7653 Aug. 10,1917 Virginia Usuel Rasidanca of Decedent 10b. County 10c. City, Town or Location show the Marylar 10d. Insida City Limits r than "natural", or items 23s or 28s-f sho the Medical Exercises must be notified at 1 Yes 2 No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zlp Coda 10g. Citizen of Whet Country? 4807 Mori Drive Funeral 20852 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Detes: 11. Marltal Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important if Health and Mental Hygiene. Important if item 27 is marked other than "natural", or he any injury or other traumatic event, the Medical Examines once. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: p Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Medical Registered Nurse 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Meiden Sumeme) Be 2 Guy LaPhew Lizzie Blanche Smith 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Silas R. Alexander 4807 Mori Drive Rockville, Maryland 20852 20b. Plece of Disposition (Neme of cematary, crematory or other pleca) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ⊠ Buriei 2 □ Cremetion 3 □ Removel from Steta 4 ☐ Donetion 5 ☐ Other (Specify) Laphew Family Cemetery 3/05/97 Roanoke, Virginia 21. Signeture of Funaral Sarvice Licansee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. Latter 500 University Blvd., W., Silver Spring, MD 20901 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter tha moda of dying, such as cerdiac or raspiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical PANCREARC CARCINOMA 7 montes Examiner Due to (or es e consequence of) Examiner physician and s the burial-transit Sequentielly list conditions, if eny, laeding to Immediate causa. Enter Undarlying Cause (Diseese or injury that initiated events rasulting in death) Lest Due to (or es e consequence of): Box 68760, Physician/Medical Dua to (or as a consequence of): nse n P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 6 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 8 24b. Were eutopsy findings aveilable prior to completion of ceuse of deeth? Completed 24a. Wes en eutopsy performed? has certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of Injury To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 28d. Describe how Injury occurred Certification: 28c. Injury et Work? After 1 Neturei 2 Accident 5 Pending Investigation 1 Yes 2 No 6 Could not ba 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) 3 ☐ Suicida 28e. Plece of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 HomicIde 150 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, and due to the ceuse(s) end manner as steted.

2 Madical Examinar: On the basis of axamination and/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to tha cause(s) end menner steted. 29e. Certifier (Check only 29b. Signatura and title of certifier 29c. Licansa number 29d. Data signed (Month, Dey, Year)

State Registrar

DANIEL

31. Dete filed (Month, Dey, Yeer) MAR 0 5 1997

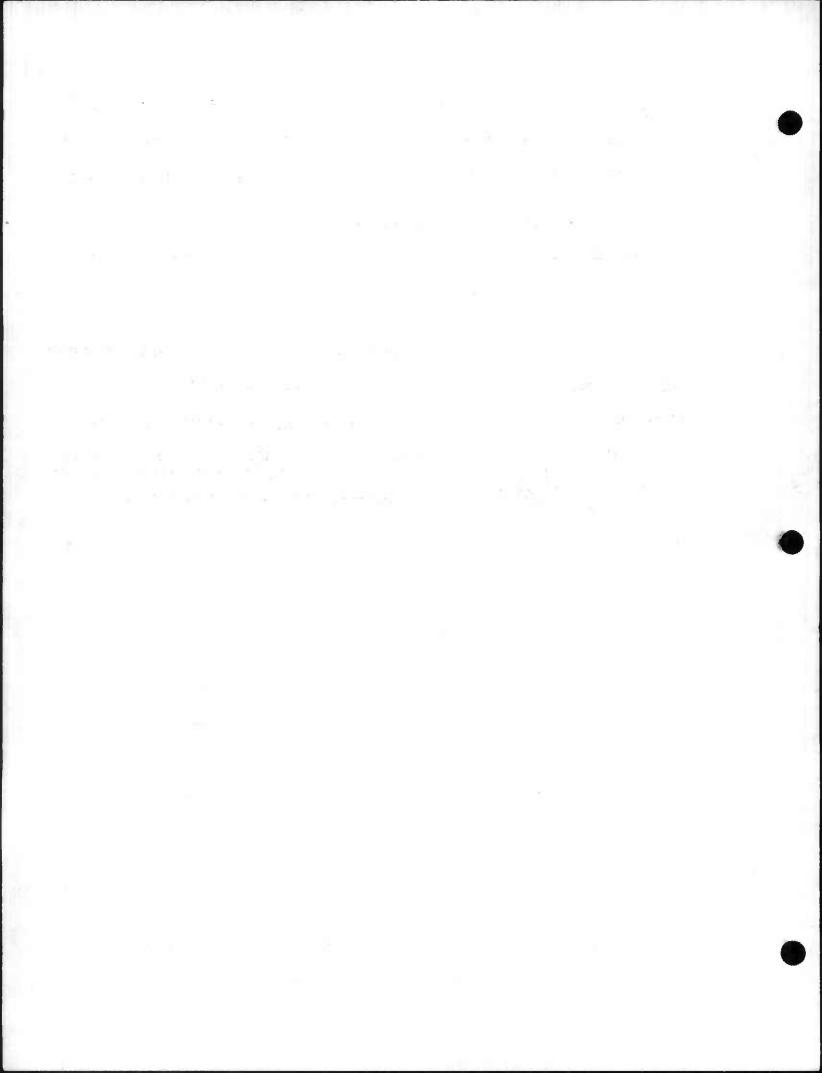
Kosenthe

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

10400 CONNECTION AV 606 KENSINGTON, MD 20895 ROSENBLUM 32. Registrar's Signeture wie Davidson-Randall

MD

		4 Description No. 1 Annual Pro-	-41	Cert	ificate of	Death	7	Reg. No.	97 081
Physicia /Medic	_	Decedent's Neme (First, Middle, La Stephen	Adk:	ins			2. Deta of De Month March		3. Time of De 10:23
Examin	_	4a. Fecility Name (If not institution, giv Malcolm Grow	e street and number) Medical Cente	er		4b. City, Town, or I	ocation of Deat		
uneral rector			7. Age (In yrs. 49	last birthdey) Yrs.	If Undar 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, De		9. Birthpiece (State or Fr Country) Lafayette, I
M III		Usuel Residence ot Decedent 10e. Stete 10b. County	10c. Cit	y, Town or Loca	ation				10d. inside City L
Pied I	ctor	Maryland Prince C	George's Te	emple H	ills				1 □ Yes 25
23a or 2	Funeral Director	10e. Street end Number 4908 Brentley Ro	pad		10f. Zip Code 20748			10g. Citizen of V United	
if, or flems	by Fune	11. Maritei Status Nevar Marriad 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Evar in U Armed Forces? 1 Yes 2 XXV If Yes, Giva Yeer or Detas:	lf Y	as Decedent of H Yas, specify Cub	dispanic Origin? (S an, Maxican, Puart Specify:	pecify Yas or No Rican, etc.)		e - American Indian, ck, White, etc.
han 'natura e Medical E	Completed	15. Decedent's Et (Specify only highest gre Elementery/Secondary (0-12)	lucation	(Give ki	_	during most of wor d)	king		usiness/industry
event, II	Be	17. Fether's Neme (First, Middle, Last) Elmer E. Adkins	3	Resea	rch Anal	18. Mothar's Nam		Maidan Suman	
7 is mark traumatic	10	19e. informent's Neme/Reletionship (Elmer Adkins	Type, Print)			and Number or Ru	rel Routa Numb	er, City or Town,	
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at some.		20a. Method of Disposition 1 Buriai 2 XX emetion 3 4 Donation 5 Other (Specific	Helfickel Holli State	14908 Place of Dispositi emetery, creme Crema	tion (Neme of story or other ple	Road, T Mar	ch 9,	20c. Location -	City or Town, State n, Maryland
any inju		21. Signature)of/Funeral Service Licen	IN			a Ferry R	Funera		inc 6633 Old
sician edical miner	Jet.	224 Part1 Enter the disease or con- shock, or heart failure. List only Immediate Cause (Finel disease or condition resulting in deeth)	e. <u>Suoc</u>	EN DE	ATIN	ig, such as cardiac	or raspiratory a	11651,	Approximeta Interval Batwee Onset and Dee
	Examiner	Sequentially iist conditions, if any, leeding to immediate cause. Enter Undertying Cause (Disease or injury	b. Due to (o	r es e conseque	enca of):				
3 00	edic	that initialed events resulting in deeth) Lest	Due to (o	r es e conseque	ence ot):				
od for t	Physician/M	Pert ii. Other eignificant conditione co	ontributing to death but not res	ulting In the und	ertving causa giv	ven in Pert I.	23b. Did	tobacco use coi	ntribute to the cause of d
	by Phys	HYPERTEN SION			onying obdox gir		10	1 -	3 Probably 4 □ Uni
a C							24e. Wes perfo	an autopsy med?	24b. Were eutopsy findi available prior to completion of caus of death?
es been s	npie							res 2 Ano	1 ☐ Yes 2KDNo
ate hes been s page 2 should	Completed	OF Ween and extend to we stire!					101		12.00 42.00
his certricate hes been s il director, page 2 should	To Be	27. Menner of Deeth 1 Deblaturel 5 □ Pending	28e. Deta of injury (Month, Dey Year)	PR/Outpatient 28b. Time ot injury	3 DOA Oth 28c. Injur Wor M 1	4 U Nursing H	th (Check only come 5 - Resid		er (Specify)
Virector: After this certificate has been s in by the funeral director, page 2 should	To Be	examiner? 1 ☐ Yes 2 ☑ No 27. Menner ot Deeth 1 ☑ Staturel 5 ☐ Pending	28e. Deta ot injury (Month, Dey Year)	28b. Time of injury	28c. Injur Wor M 1	ler: 4□ Nursing H yat k?	th (Check only come 5 - Residue) 28d. Dascribe	dence 6 Other	er (Specify)
Virector: After this certificate has been s in by the funeral director, page 2 should	edicai Certification: To Be	examiner? 1 Yes 2 No 27. Menner of Deeth 1 No No Toeth 2 Accident 3 Suicide 4 Homicide 29a. Certifier Could not be determined	28e. Deta ot injury (Month, Dey Year) 28e. Pleca ot injury - At ho	28b. Time of injury	28c. Injur Wor M 1 t, tectory, offica	er: 4 Nursing H yat k? Yes 2 No	th (Check only of the Check only only only only only only only only	dence 6 Other own injury occurrence of Numbers, Street and Numbers, Street	er (Specify) red er or Rural Route Number,
Pundral Director: After this certificate hes been spletely filled in by the funeral director, page 2 should	Medical Certification: To Be	examiner? 1	28e. Pleca ot Injury (Month, Dey Year) 28e. Pleca ot Injury - At he building, etc. (Specify relician: To the best of my known iner: On the basis of examine)	28b. Time of injury	28c. Injur Wor M 1 t, tectory, offica ccurred et the tirstigetion, in my o	er: 4 Nursing H	th (Check only of the Check only only only only only only only only	dence 6 Other own injury occurred and Numbers, Street and Numbers, Stele) cause(s) and medete and place, and the signed	er (Specify) red er or Rural Route Number, enner es steted. and due to the cause(s) d (Month, Dey, Year)
Virector: After this certificate has been s in by the funeral director, page 2 should	Medical Certification: To Be	examiner? 1	28e. Deta ot injury (Month, Dey Year) 28e. Pleca ot Injury - At he building, etc. (Specify iner: On the basis of examined end menner steted.	28b. Time of injury me, term, stree wledge, deeth o ion and/or Investigation 23e) (Type, Pr	28c. Licens 28c. Licens 28c. Licens t, tectory, offica ccurred et the tir stigetion, in my o	er: 4 Nursing Hy at k? Yes 2 No ne, dete end pleca, pinion, death occur e number	th (Check only of the Check only only only only only only only only	dence 6 Other own injury occurred and Number of Street and Number of Str	er (Specify) red er or Rural Route Number, nner es steted. and due to the cause(s) d (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** IAMES MARCH 199 /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c County of Deeth Examiner 7. Âge (In yrs. lest blrthday) If Under 1 Year If Under 24 Hrs. 8.

7 / Months Days Hours Min | 8. Washington Adventist Hospital Montgomery 8. Date of Birth (Month, Dey, Year) 6. Sex **Funeral** Birthpiece (State or Foreign Country) 1 M 2 □ F Director 434-26-0227 74 June 24,1922 Colfax, LA Usuel Residence of Decedent 12 should be filed within 72 hours after deeth with the Manyland nand Mental Hygiene.
Is marked other than "natural", or items 23s and 25s and 15s State 10b. County 10c. City. Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be nothed at Directo MD Prince Georges Y☐ Yes 2☐ No Hyattsville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6200 20th Place 20782 U.S.A. Funeral Rece - American Indian, Black, White, etc. 11. Merital Status 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lt Yes, specify Cuben, Mexican, Puerto Rican, etc.) I Tyes 2 □ No If Yes, Give 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No þ Specify: Specify Black 3 Widowed 4 Divorced Yeer or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuei Occupetion 16b. Kind ot Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Eiementery/Secondery (0-12) College (1-4or 5+) 3rd Construction Worker Air Power 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be permit. Pages 1 and 2 should by Department of Health end Menta Important: If Item 27 is marked any Injury or other traumatic events. 2 Thomas Allen Luella Nelson 19e. Intorment's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Emmie Allen - Wife 6200 20th Place Hyattsville, MD 20782 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Buriel 2 ☐ Cremetion 3 ☐ Removel trom State 4 ☐ Donetion 5 ☐ Other (Specify) Harmony Memorial Park 3-8-97 Landover, MD 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility Marshall's Funeral Home, Inc. Mars 23e. Park. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest,

Approximately a specific control of the cont Approximete Intervei Between Onset end Deeth **Physician** CARRIDMYU /Medical Immediate Cause (Finei disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury and Records, P.O. Box 68760, physician Physician/Medical the thet initieted events resulting in death) Lest Due to (or es e consequence of) signed by the e Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? certificata hes t irector, page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director Be 25. Wes case referred to medical 26. Piece of Deeth (Check only one) 25/100 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 Inpatient 2 ER/Outpetient 3 DOA this 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred After 1 PNeturei 5 Pending after deeth.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end manner as steted.

| Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) end menner steted. 29e. Certifier edical (Check only one) 29b. Signeture end title of certifier 29d. Dete signed (Month, Dev. Year)

person who completed cause of deeth (Item 23e) (Type, Print)

alisaelle

20910

State Registrar Hector

MAR 05 1997

31. Dete tiled (Month, Dey, Year)

while the time at him

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SR. MARCH ICHARD 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY Hours Min. 8. Date of Birth (Month, Dey, Year) If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) Days Months 15 M 2□ F 46 220-50-8769 September 17, 1950 Washington, DC Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Maryland | Montgomery Poolesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15121 Montevideo Road 20837 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced White 15. Decadent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Builder Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Charles Ernest Burgdorf Julia Knox 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Louise C. Burgdorf/Wife 17601 Soper Street, Poolesville, Maryland 20837 20b. Place of Disposition (Name of cametery, cremetory or other place) March 7 20a. Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 1997 4 Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, MD of Furteral Service Ligery 21. Signatu 22. Name end Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 Rockville, Maryland 300 West Montgomery Avenue 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 20850-2805 Approximete interval Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) Liver faulure 3 months Alcohol 10 years abuse Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequenca of): se of death? Unknown sy findings ior to of cause No No

Physician /Medical Examine

Physician

/Medical

Examiner

10a, State

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Funeral

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Completed

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Funeral

Director

r than "natural", or items 23a or 28a-f show the Maulcal Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours effer death with t. Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or items 23a or 2 any injury or other traumatic event, the Mental Exemples 20 or 2 ARM

Baltimore, Maryland 21215-0020

the Marylend

To the Hospital or Attanding Physician: The law requires that the daath certificata be asscuted within 24 hours after daath.

To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by the funaral director, page 2 should be detached for use es the buriel-transit completaly filled in by the funaral director, page 2 should be detached for use es the buriel-transit signed by to be detach

Division of Vital Records, P.O. Box 68760.

Physician/Medical Medical Certification:

resulting in death) Last	Due to (or as a consequenca of	f):		
Pert II. Other significant conditions	contributing to death but not re	suiting in the undertying	g cause given In Part I.	23b. Did tobacco use co	antributa to the cause of d
				24e. Was an autopsy performed?	24b. Were autopsy find eveileble prior to completion of caus of death?
25. Was case referred to medical examiner?			26. Place of De	eeth (Check only one)	
1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐ I	DOA Other: 4 Nursing	Home 5 ☐ Residence 8 ☐ Oth	ner (Specify)
27. Menner of Death 1 ☑ Neturel 5 ☐ Pending 2 ☐ Accident investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of tnjury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	red
3 Suicide 6 Could not determined		nome, farm, street, factority)	ory, office	28f. Location (Street end Numb City or Town, Stete)	ber or Rural Route Number
29a. Certifier 1 Certifying P	hysician: To the best of my kn minar: On the bests of examin	owledge, death occurre ation and/or investigation	ed et the time, date and place on, in my opinion, death occ	ca, and due to the cause(s) end me curred et the time, dete end placa,	enner as stated. and due to the cause(s)

29c. License number D 3 8 0 7 6

29d. Date signed (Month, Dey, Year) March 3 1997

Poolesville MD 20837

10 State Registrar

31. Date filed (Month, Dey, Year) MAR 0

29b. Signature and title of certified

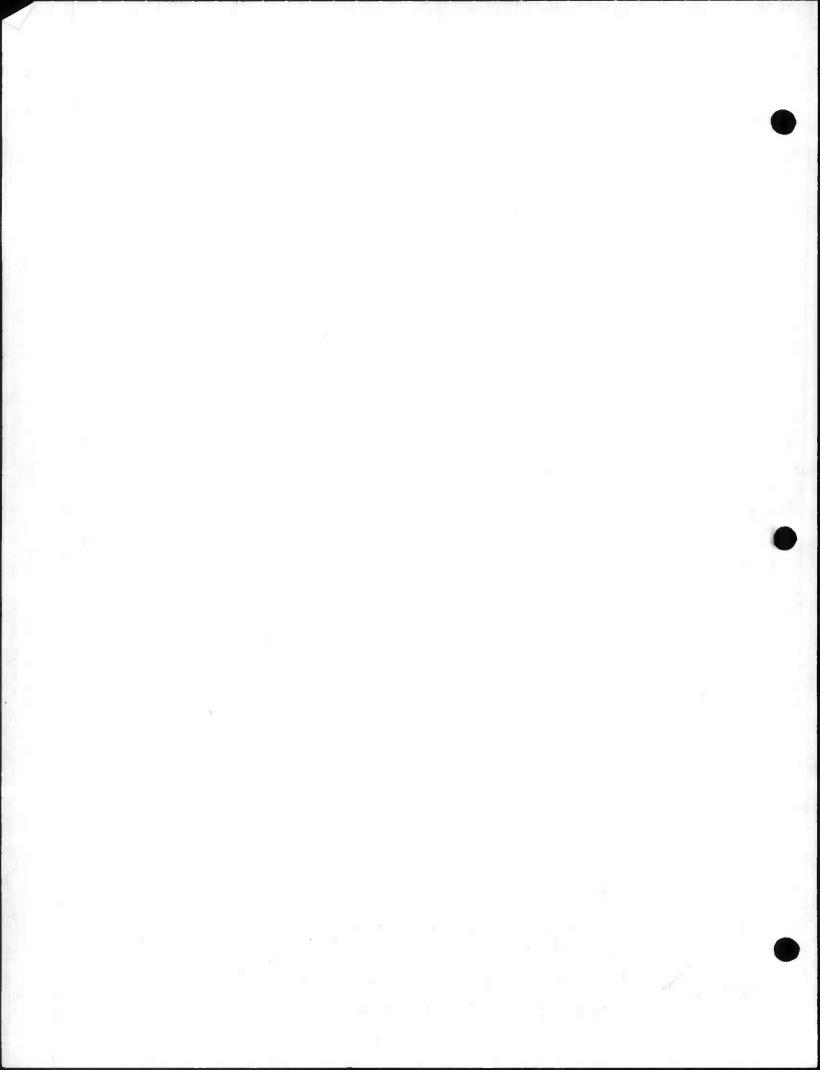
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Leanurd Sux MD Bex 108 32. Registratis Signeture hia Davidson

DHMH 16 Ray 6/95

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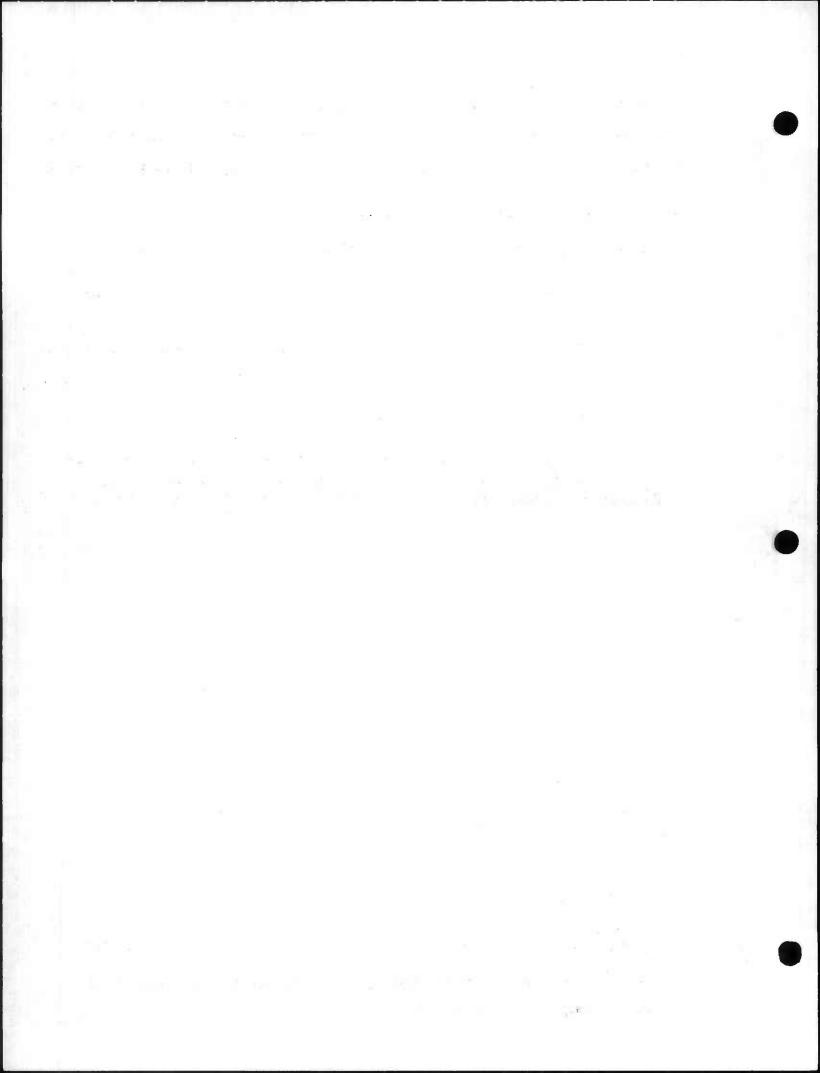
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene

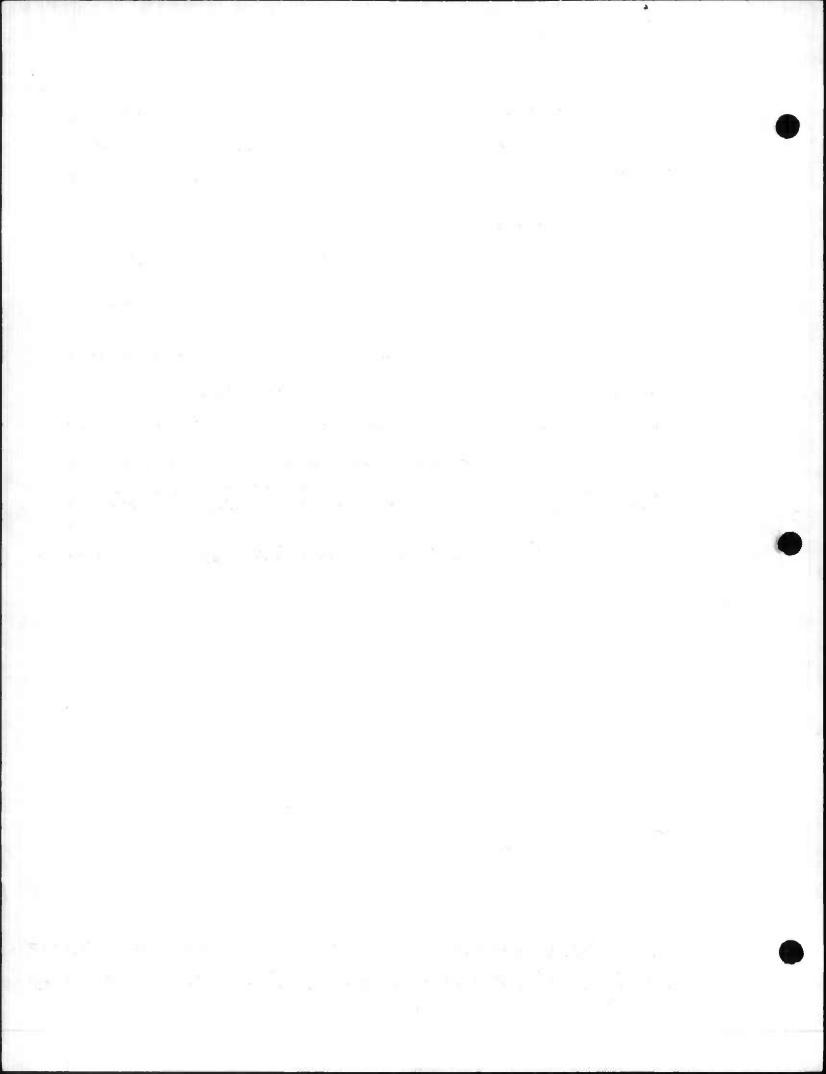
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						Cer	tificate d	of De	eath		Reg. No.	5 1	0010
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edical	_	TATRICIA			У,			30	Yd	Mas		1997	8 501
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	ı	Washington	Ad	venti	st Hos	pital			Tako	ma Par		ONTGO	MERY
eral		5. Sociel Security Number	6. Se		7. Age (In yrs.	lest birthday)	If Under 1 You Months De		Under 24 H	Irs. 8. Date of (Month,	Birth Day, Year) 13,19	9. Birtl	plece (State or F
tor		216-40-6825	11	☐ M 2[2 KF	54	Yrs.	MOILIS	ys	riours M	May	13,19	42 Wa	nplece (State or Funtry) Sh. DC
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by Funeral Director		10e. Street end Number					10f. Zip Cod					on of Whet Co	untry?
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Pur		11. Meritel Stetus		12. Wes Dec Armed Fo	edent Ever in U		Ves Decedent	of Hispe	enic Origin?	(Specify Yes or erto Rican, etc.)	No- 14	. Rece - Amer Black, White	
I E		1 Never Merried 2 Mai		1 ☐ Yes If Yes, Gi	2.⊠No ve		☐ Yes 20		Specify:	,	S		lack
d b		3 ☐ Widowed 4 ☐ Divorce	d	Yeer or D	Detes:				, , , ,			pecity.	
Completed		15. Deceder (Specify only higher	nt's Edu	ication le completed)		16e. Deced (Give	ent's Usuel Oc kind of work do OO NOT use re	cupetlo	n ing most of v	vorking	16b. Kind	of Business/I	ndustry
l ar		Elementery/Secondery (0-12)		2 College (1-4or 5+)	1	•				II C	Corre	rnment
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To		19e. Informent's Neme/Reletion:								Rural Route Nur			20
	-	Jerry E. Be	oyd	(Hus			466		on Dr	rive, U			
5	2	20e. Method of Disposition 132 Burial 2 Cremetion	3 □ E	Removei from	State 20b. F	Plece of Dispos cemetery, crem	sition (Neme or netary or other	f plece)		Dete	20c. Loca	ation - City or 1	rown, Stete
d		4 Donetion 5 Other (5			Li	ncoln	Mem.	Cer	n.	3/7/97	Suit	land,	MD
eouce.		21 Signature of Funerel Service	Licens	90 1			Neme end Ad						
8		(tenso	K	10	new	CLIA B	NOMDEN	J.F.	UNERA	L HOME 20850	, P.A	•	
		23a. Pert1. Enter the disease, o shock, or heert feilule. List	r compi	icetions thet	aused the deet	-						1	Approximete
an	1	allock, of fleett fellule. Lis	t Offig Of	ie ceuse on e	eci iiie.							1	Interval Betwee
al		immediete Ceuse (Finei											
ner		diseese or condition resulting in deeth)		NIE	TASTA	TIC	BREA	ST	CF	FRCIN	OMA		~ 1 ~
<u>a</u>					Due to (d	or es e conseq	uenca of):						
Examiner				D. ————			,						
/Medical Examir		Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or injury			Due to (c	or as e consequ	uence of):						
<u>e</u>		Cause. Enter Underlying Ceuse (Diseese or injury that initiated events	₹ ⟨	o								i	
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Š			L .	1									
Physician	L												
by Physic	F	Pert ii. Other significant condition	ons cor	itributing to de	eath but not res	ulting in the un	derlying cause	given i	n Pert I.	23b. D	ld tobacco us	e contribute	to the cause of
문										1	Yes 2	No 3 Pr	obably 45 U
þ													
Completed										24e. W	as en eutopsy rformed?	8	Vere eutopsy fine veileble prior to
ald m	-											0	ompletion of cau f deeth?
E O										10	□Yes 2 💢	No 1	☐Yes 2☐ No
To Be		25. Wes case referred to medical exeminer?	ıl					26	S. Place of D	eeth (Check on	ly one)		
2		1 ☐ Yes 21 No	F	lospitel: 1 🔽	npatient 2	ER/Outpetlent	3□ DOA	Other:	4 Nursing	Home 5 Re	esidenca 6	Other (Spec	ify)
Ë	2	7. Menner of Deeth		28e. Dete	of Injury th, Dey Year)	28b. Time of Injury	28c. li	njury et Nork?		28d. Describ	e how injury o	occurred	
Certification:		1 Neturel 5 ☐ Pendir 2 ☐ Accident investi		(1870)	in, boy rour,	mjury			2 🗆 No				
E S		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be nined	28e. Plece	of Injury - At ho	ome, ferm, stre	et, fectory, offi	ce		28f. Location	(Street and I	Vum <i>ber</i> or Ru	rai Route Numbe
Se L		4 I Homodo		Dulidi	ng, etc. (Specii)	Y)				. City or	rown, Stete)		
<u>8</u>		29e. Certifier 15 Certifyir	ng Phys	ician: To the	best of my kno	wledge, deeth	occurred et the	e time, d	dete end ple	ce, end due to th	ne cause(s) er	nd manner es	steted.
edical		(Check only 2 Medical one)	Examin	ner: On the ba	asis of examination of stetled.	tion end/or inve	estigetion, in m	y opinio	on, deeth oc	curred et the tim	e, date and pl	aca, and due	to the ceuse(s)
Medical Certification:		9b. Signeture end title of certifie					29c. Lice				29d. Dete	signed (Month	, Day, Year)
		1 M. Sr	Son	The same			D	-1	787	4		3-9	
	1					00-1 75				/		•	1
	3	0. Neme and eddress of person	Who co	mpleted caus	e of deeth (Item	1 23a) (Type, F	rint)	CAS	TAGE	CIM	Mr	207	122
	-				a alata da Oi	11-38	MG				/		
State	3	1. Dete filed (Month, Dey, Year)	0 -	32. R	egistrer's Signe	Rure	10. 0.00						
strar		WAR	U 9	133/	a wax	rundson-	Manager						

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

		A Board of the Control of the Contro			Certific	ate of	Death		Reg. No.	97 0818
Physici /Medio Examir	cal	Decedent's Neme (First, Middle, I Hugh P. Bt 4e. Fecility Neme (If not institution, g	urns, Sr.				4b. City, Town, or	2. Dete of De Month Februar Location of Deeth	Dey y 28, 1	Yeer 997 7:00 P
Funeral Director		Collington Life 5. Sociel Security Number 6. 153-14-1294 Usual Residence of Decedent		r e (In yrs. lest 95	t birthday) If Ur Yrs. Mont	nder 1 Year		s. 8. Dete of Bird (Month, De	h y, <i>Year)</i>	e George's ^{9. Birthplece} (State or Fore Country) New Jersey
show	1	10e. Stete 10b. County		10c. City, T	own or Location					10d. Inside City Lim
r 28a-f	Director	Maryland Prince (10e. Street end Number	George's	Mito	chellvil	1e Zlp Code			10g. Citizen of N	1 ☐ Yes 2 ☑
netural, or Homs 23a or 28a-f show	by Funeral D	10450 Lottsford 1 11. Maritel Stetus 1 Never Married 2 Married 330 Widowed 4 Divorcad	12. Wes Decedent I Armed Forces?			ecedent of I specify Cub	721 Hispenic Origin? (ean, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	14. Rac	
than	Completed	15. Decadent's (Specify only highest g	Education	+)			pation during most of wo d)			White usiness/Industry
other other	Be Co	17. Fether's Name (First, Middle, Las	st)		Engineer		18. Mother's Na	ame (First, Middle,		Government
Men	10	James Burns	C					y Spiche		
9 8 8		19e. Informent's Name/Reletionship Hugh P. Burns,						Rural Route Number		inia 22151
popularies of Health Important: If them 27 any Injury or other tr		20e. Method of Disposition 1 🖾 Burial 2 □ Cremetion 3 4 □ Donetion 5 □ Other (Special Control of	Removel from State	20b. Plece	e of Disposition (etery, cremetory	Neme of or other ple	ice)	Dete	20c. Location -	City or Town, Stete
hysician /Medical xaminer	niner	23e. Pert1. Enter the disease, or conshock, or heert feilure. List only immediate Cause (Finel disease or condition resulting in death)	Chron	ic c		·VCT				Approximete Intervel Between Onset end Death
ng physician end es the buriel-transit	edicai Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c		e c <i>on</i> sequenca					
e ettending phy od for use es th	an/Medi	resulting in deeth) Lest	d	70e to (or es	e consequenca (oi).				
02	Physician/M	Pert II. Other significant conditions	contributing to deeth bu	t not resultin	g In the underlying	ng cause giv	ven in Pert I.	23b. Did t	obacco use co	ntribute to the cause of dee
signed by d be detec	by							1	fes 2□ No	3 □ Probably 4 ☑ Unknow
has been ge 2 shoul	Completed							24a. Wes perfo	en eutopsy med?	24b. Were sutopsy finding eveilable prior to completion of cause of deeth?
cate har,	e Co	25. Wes case referred to medical					26 Plece of De	ath (Check only o		1 ☐ Yes 2 ☐ No
tific tor,	-	examiner?	Hospital: 1 ☐ Inpatie		b. Time of	DOA Oth	ner: 4 Nursing	Home 5 □ Resid		
this cer ral direc	ToB	1 ☐ Yes 2 ☐ No 27. Menner of Deeth	28e. Date of Injur				TKT			
ter deeth. Irector: After this n by the funeral di	ToB		on Month, Dey	Year) ry - At home	Injury M , ferm, street, fac	1 🗆	Yes 2□No	28t. Location (S City or Tox		er or Rural Route Number,
ter deeth. Irector: After this n by the funeral di	Certification: To B	27. Menner of Deeth 1 Naturel 5 Pending Investigative 3 Sulcide 4 Homicide 6 Could not determined	Month, Dey 28e. Place of Injubuilding, etc hyslclen: To the best of	ry - At home (Specify)	M, ferm, street, fac	1 □	me, dete end plec	City or Tox	m, Stete)	onner as steted
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				State of	Marylar		artmen <i>rtificat</i>			Mental H	ygiene Reg. No.	97	08	188
	Physic		Decedent's Neme (First, Middle, Last LENA BURDWISE)						2. Dete of D Month		Yaer	3. Time o	
0	/Medi Exami		4a. Facility Neme (If not institution, giva BROOKE GROVE NU					4	b. City, Town,	or Location of Dea		of Deeth	2:10) AM
-	Funeral Director		5. Sociel Security Number 6. Se 577–32–1303			last birthday) Yrs.	Months	1 Year Days	If Under 24 Hours M	in. 8. Dete of B		9. Birthple Count	ece (State ory) TH CA	or Foreign ROLIN
	death with the Maryland rms 23a or 28a-f show r must be notified at	tor	Usuel Residence of Decedent 10e. State 10b. County MARYLAND MONTGOI	MERY	10c. Cit	OLNEY						10	d. insida C	
	or 28	Director	10e. Street end Number				10f. Zip				10g. Citizen of	Whet Count	ry?	1
020	d within 72 hours effer death with the Marylar jiene. r than "natural", or liems 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	17209 BLOSSOM V	IEW DRIV 12. Was Deceded Armed Force 1 □ Yas 2 It Yes, Give Year or Dete	ent Ever in U es? No		Was Decedif Yes, specific Yes	cify Cuba	spenic Origin?	(Specify Yas or Nerto Rican, etc.)		e - Amarica ck, White, a	n Indian, tc.	
21215-0020	d within 72 hours effer jiene. r than "natural", or Ne ing Medical Example	Completed	15. Decedent's Edu (Specify only highest grad Elementery/Secondary (0-12)	cetion a com <i>plated)</i> College (1-4	or 5+)	(Give	dent's Usua kind of wo DO NOT us ES CL	rk done d se ratired	luring most of a	vorking	16b. Kind of B	usiness/Ind		
Maryland	should be filed within and Mental Hygiene. I marked other than umatic event, the Mental County of the Mental Coun	To Be C	17. Fether's Name (First, Middle, Last) SAMUEL GOLDMAN						NETTIE		e, Maiden Suman WN)	na)		
altimore, Mar	permit. Peges 1 and 2 should Depertment of Health and Mer Important: If Item 27 is marke any injury or other traumatic 2002e.		19a. Intorment's Neme/Reletionship (T) EUGENE BURDWISE 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F 4 □ Donetion 5 □ Other (Specify)	(SON)	ete	1720 Plece of Disponentery, cre	9 BLO osition (Nar matory or o	SSOM ne of ther plac	VIEW D	Pural Route Num PRIVE - 0 Date 2/25/97	LNEY, MA	RYLAN City or Tov	ID 20 vn, State	0832
Baltin	Depertment Personal Importarian any injur		21. Signature of Funeral Solvice Cicens	-/-	Coll.	D 2	2. Name er ANZAN	d Addres	s of Fecility	G MEMORI	AL CHAPI	ELS. I	NC.	20852
	Physician /Medical Examiner		Immediate Cause (Final disease or confidence of condition resulting in death)	ications thet ceune cause on each	DIAL I	NFARCT	CION	e ot dyln	g, such es cerc	llac or respiratory	errest,	į	Approximet Interval Bat Onset and I	ween Deeth
o,	cete be executed by siclan end the burial-transit	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause, (Disease or Injury	b		or es e conse								
Box 68760,	requires that the death certificate be executed seen signed by the ettending physician end thould be deteched for use as the burial-transit	n/Medical	Cause (Disease or Injury thet initieted events resulting in deeth) Last	d	Due to (o	r es e consec	quence of):							
P.O. Bo	that the death led by the etter deteched for u	by Physician/M	Pert II. Other significent conditions con SENILE DEMENTIA, A				inderlying c	euse give	en in Pert I.		tobacco use co			
Records,		Completed by	HYPERTENSION							24a. We	s an autopsy formed?	ava	re eutopsy t ilable prior t apletion of d eeth?	0
	The ate h									1□	Yes 20 No	1 🗆	Yes 2	No
Vital	Physician: Th rthis certificate ral director, par	o Be	25. Wes case reterred to medical exeminer? 1 Yes 2 No	lospitel:	etiont 2	ER/Outpetie	nt 3 DC	Othe		Deeth <i>(Check only</i> THome 5 Res		or (Specify		
ion of	F F E	ation: T	27. Manner of Deeth 1 Neturel 5 Pending 2 Accident Investigation	28a. Dete of (Month,		28b. Time o Injury		8c. Injury Work		T	how injury occur			
Division	5 5 5 G	Certification:	3 Suicida 6 Could not be 4 Homicide determined	28e. Plece of building	Injury - At he , etc. (Specif	ome, farm, st y)	reet, fectory	, office			(Street and Numbown, State)	per or Rural	Route Num	ber,
	To the Hospital within 24 hours of To the Funeral I completely filled	edical	29e. Certifier Certifying Physical Check only one)	ner: On the basi end menne	s of examine	wiedge, deet tion end/or in	h occurred vestigation	et the tim in my op	e, dete end pla pinion, death oc	ice, and due to the curred et the time	ceuse(s) end ma , date and place,	anner es ste and due to	ited. the cause(s	5)
	To the To the Comp	Me	29b. Signature and title of certifier	La			100	Licanse	740 (ML)	29d. Date signe			
,	6		30. Name and eddress of person who con ROBERT FIELDS, M.D.				Print)					2083		
	Sta		31. Dete filed (Month, Day, Year) MAR 0 3	32. Reg	Istrer's Signe	ture		,						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Death Mogth Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death SILVER SPRING CMOONEN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Jast birthdey) Birthplace (State or Foreign Country) Days 1 M 2 B Yrs. 489.52.0796 +Illinois Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits X ☐ Yes 2 ☐ No Washington D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 20008 3305 Woodley Road, N.W. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Malden Sumeme) Anna Hoelscher William Heidbreder 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 3305 Woodley Road, N.W. WDC 20008 Joan Habib/Daughter 20b. Place of Disposition (Neme of commetery, cremetery or other place) Mt. Comfort Crematory 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Alexandria, Va. 3/4/97 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue N.W. WDC Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final GRAM NEGATIVE DM disease or condition resulting in death) 2 MOURIS 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 PUnknown 24b. Were autopsy findings available prior to 24e. Wes an autopsy performed? completion of cause of deeth?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

to or 28a-f show

"natural", or items 23e

The Medical

then Hygiene.

permit. Pages 1 and 2 should be filed to Department of Heelth and Mental Hygie Important: If item 27 is marked other 1 eny Injury or other traumetic event, in

Director

Funeral

þ

Completed

Be

Maryland

the

death with

filed within 72 hours after

Baltimore, Maryland 21215-0020

the buriai-trensit and physician 88 ete has been signe page 2 should be certificete director. funeral After To the Hospital or Attending within 24 hours efter deeth. To the Funeral Director: Aft completely filled in by the fur

The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

or Attending Physician:

Physician/Medicai Examiner by Completed Be Certification: To

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 25. Was case referred to medical 1 Yes 2 No 1 Dipatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1XXVeturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1 ☐ Yes 2 ☐ No

1 Griffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. (Check only one) 29b. Signature and title of cartiful 29c. License number 29d. Dete signed (Month, Dey, Year)

MAML H, ETGM 4801 G to Nav AVS

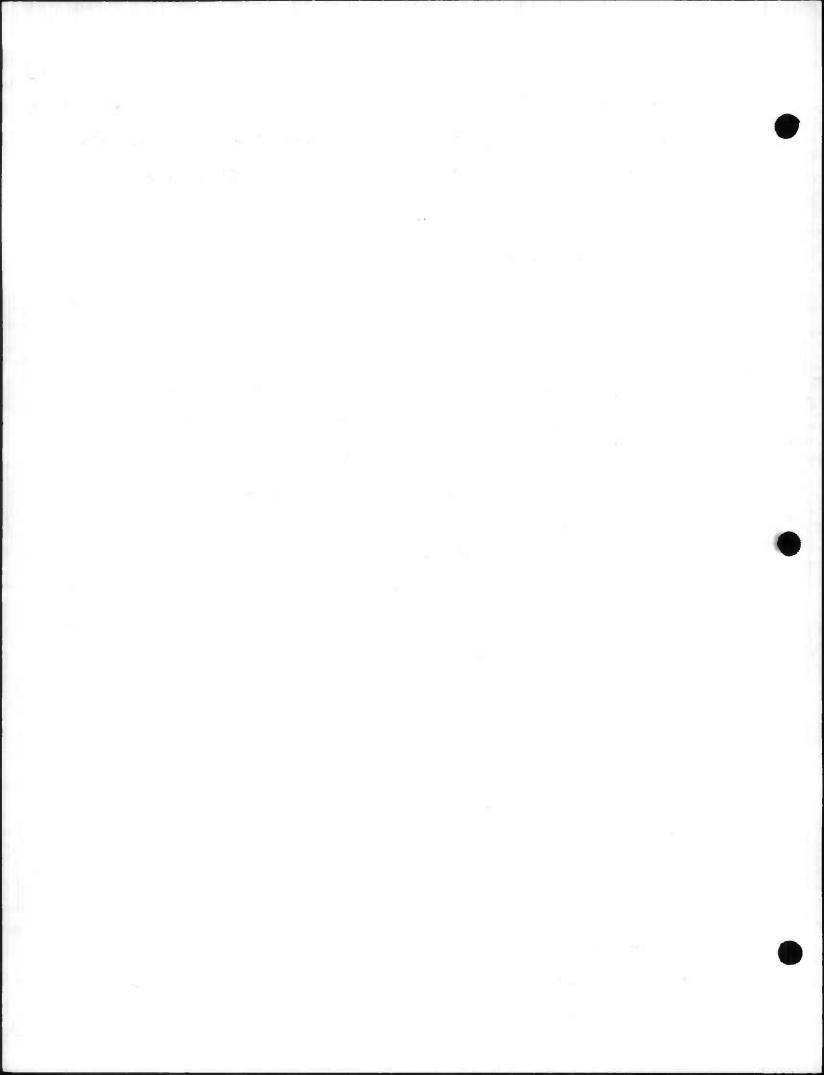
State Registrar

5

Medical

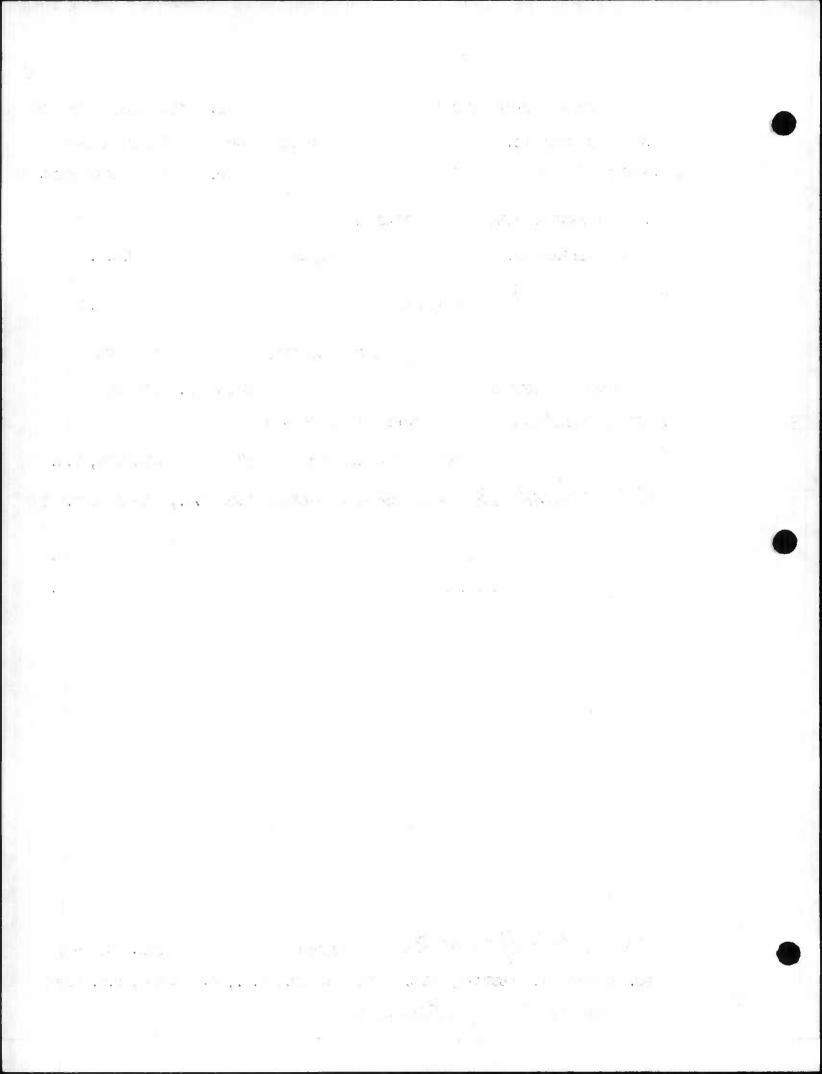
31. Date filed (Month, Day, Year) MAR 0 5 1997

SIWER SPRING MO 32. Registrar's Signature



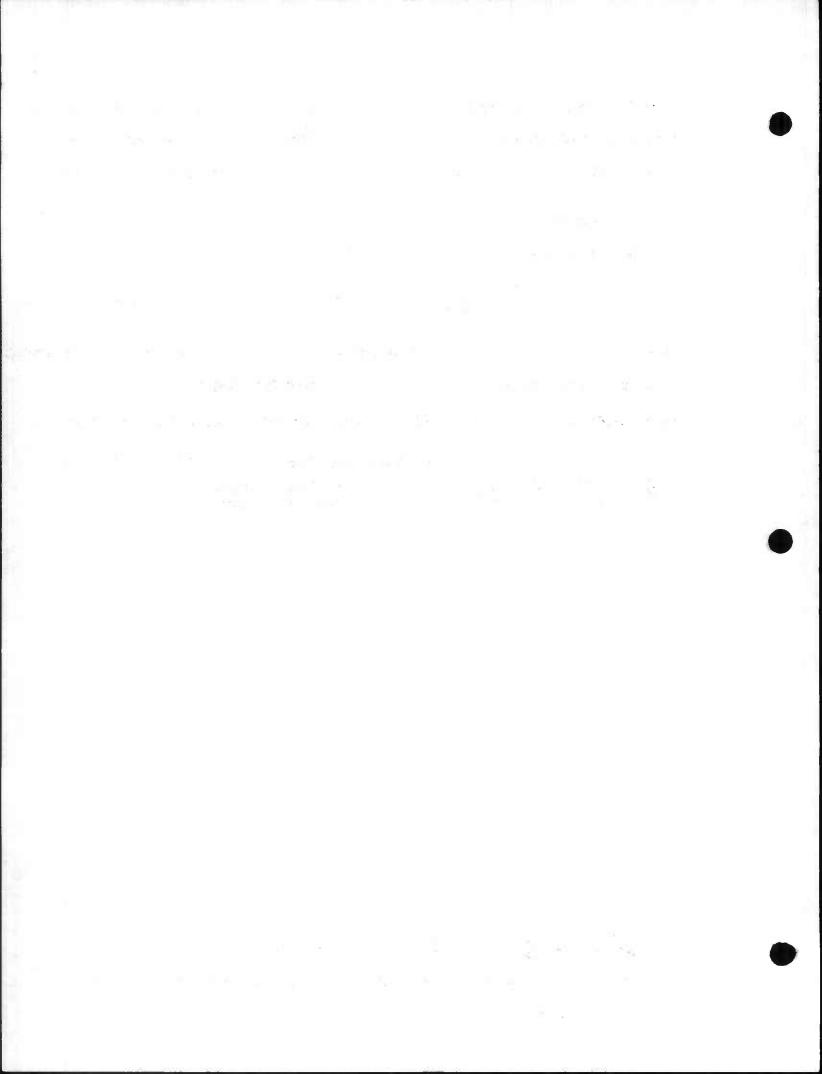
State of Maryland / Department of Health and Mental Hygiene

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Examin	ner	4811 GUILFORI					COLLEGE				Date
unerai irector	Г	5. Social Security Number 6. S		a (In yrs. la:	st birthday) If Un Yrs. Mon	nder 1 Yaar ths Deys	if Undar 24 Hrs	8. Dete of Birt (Month, Da)	h y, Year)	9. Birthplece Country)	(State or Foreign
Hector		Usuel Rasidence of Decedent		34				APR. 3	30, 1962	MASSA	ACHUSETT
how		10a. Stete 10b. County		10c. City,	Town or Location						nside City Limits
athex	cto		GEORGES		COLLEGE	PARK				1	X Yes 2 □ No
N Or 2	Dire	10e. Street end Number			10f.	Zip Code	- 1		10g. Citizen of V	What Country?	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, Middle, L	aptl	Cei	rtificate of	Death		eg. No.	/	00191
Physic	ian		*				2. Dete of Deal Month	Day	Year	3. Tima of Death
/Medi		Theodore Newco					Februar	y 20,	1997	7:34 am
Exami	ner	4a. Facility Nama (If not institution, g	iva street and number)			4b. City, Town, or L	ocation of Death	4c. County	of Death	
		Laurel Regional	Hospital		:	Laurel		Princ	ce Geo	orge
Funeral		5. Sociel Security Number 6.	Sax 7. Aga	(In yrs. last birthday)	If Undar 1 Year		8. Date of Birth (Month, Dev.	16.1	9. Birthpl	aca (Stata or Foreigny)
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72 hours after death with the Maryland neture!; or items 23s or 28s-f show dical Examiner must be notified at	2	10a. State 10b. County		10c. City, Town or Lo	cation				10	d. Inside City Limit
N P	Director	MD Howard		Laurel						I les ziglie
5 6	등	10e. Street and Number			10f. Zip Coda		1	0g. Citizen of V	Vhat Count	ry?
23a B		9376 Sewell Aver	nue		20723			USA		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Year **Physician** Ellen Burk Katherine 11:30 AM 1997 /Medical March 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2719 Creswell Rd. Bel Air Harford If Under 1 Year If Under 24 Hrs.

Months Deys Houra Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Funeral 1 □ M 2 🔀 F 212-28-8280 Director 97 April 14,1899 North Carolina Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2719 Creswell Rd. 21015 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yea or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Stetus 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mentel Hygiene. Important: If frem 27 is marked other than "natural" ---" any injury or other traumatic exercises. Biack, White, etc. 1 ☐ Yes 2 X No If Yes, Give Yeer or Detes: 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2% No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) unknown Vennie (nmn) (unknown) 2 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Ensa Lee Absher - Daughter 2719 Creswell Rd., Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Buriel 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens | 3-6-97 Bel Air, Maryland 22. Neme end Address of Facility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Md. 21009 23a. Part1. Enter the disease, or complications that bused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on trach line. Approximate Intervel Between Onset and Death **Physician** immediate Cause (Final disease or condition resulting in death) /Medical oma Examiner Examiner Dehydration due to POOV iclan and buriei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Last physiclan s the buriei Box 68760, 8 Physician/Medicai Due to (or as a consequence of): 80 esn ed by the a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown signed by 2 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Wes en autopsy performed? Completed Severe Malnutrition 1 Ven 2 No 1 ☐ Yes 2 No 25. Wes case reterred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitai: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 10 After this 28a. Date of Injury (Month, Day funerai 27. Menner of Death To the Hospital or Attending Pt within 24 hours efter death. To the Funeral Director: After th completely filled in by the funera 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At hor building, etc. (Specify) , tarm, street, factory, office 4 Homicide applicable 100 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. edical 29a. Cartifier (Check only one)

29c. License number

Law Street

MD

1997. Registars Signature Redell

29d. Date signed (Month, Day, Year)
MARCH 3 1 1997

2100)

3 3 97)

State Registrar 29b. Signeture end title of certifier

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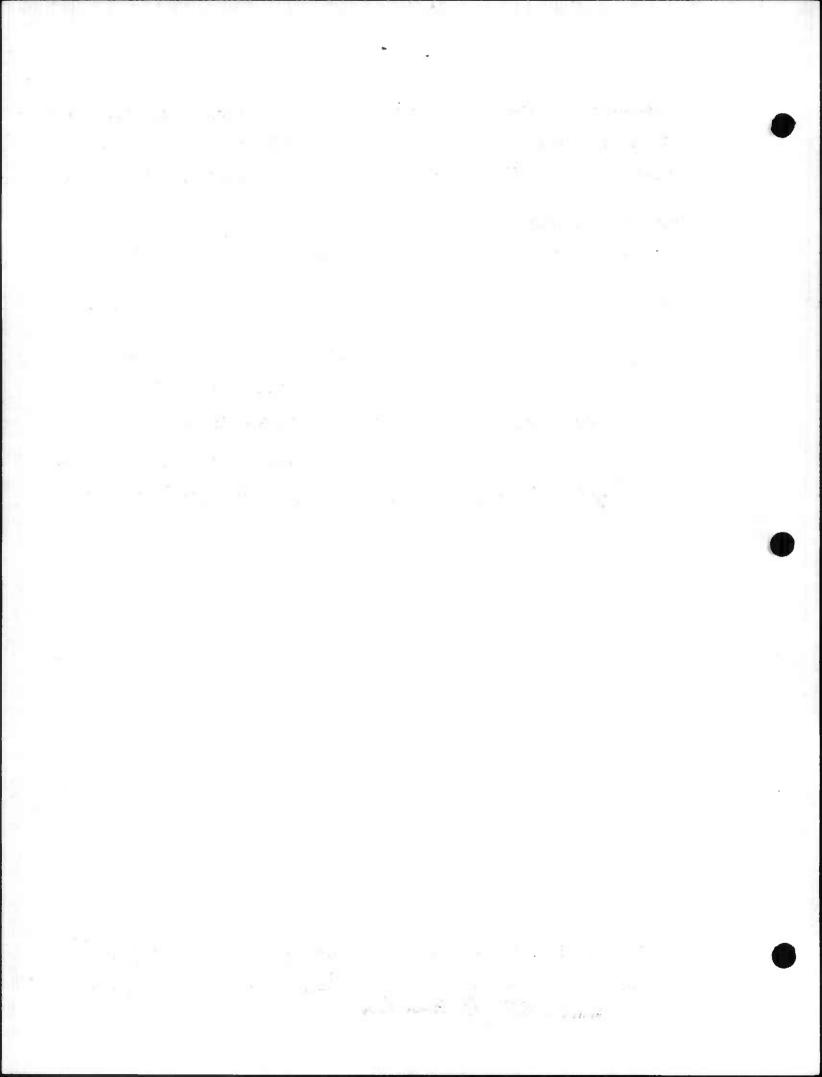
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M.

30. Name and eddress of person who completed cause of death (item 23a) (Type, Print)

LA

マケTIN



Physician /Medicai **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ă items 23a

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"natural"

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Department of Health a important: If Item 27 is any injury or other tra

Pages 1 and 2 should I nent of Health and Men

altimore, Maryland 21215-0020

the Medical Examiner must be notified at

Director

by Funerai

Completed

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Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours effer deeth.
24 hours effer deeth.
24 hours effer deeth.
25 Hours all prector: After this certificate hes been signed by the attending physicien and easily filled Director: After this certificate hes been signed by detached for use as the burdel-transit easily filled in by the furnated director, page 2 should be detached for use as the burdel-transit Medical

Division of Vital Records, P.O. Box 68760,

Pert tt. Other significant conditions con	ntributing to death but not res	sulting in the underlying	g cause given in Pert I.	23b	Did tobacco use co	ontributs to the cause of death? 3 Probably 4 Unknown
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29b. Signeture engititle of certifie	S, M.D.		9c. License number	6	29d. Dete signe March	5, 1997

KATS, M. D. - Union Memorial Hospital; Baltimore, MD

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

And Sweller Redall

State Registrar

To the Hospital or within 24 hours eft To the Funeral Di completely filled in

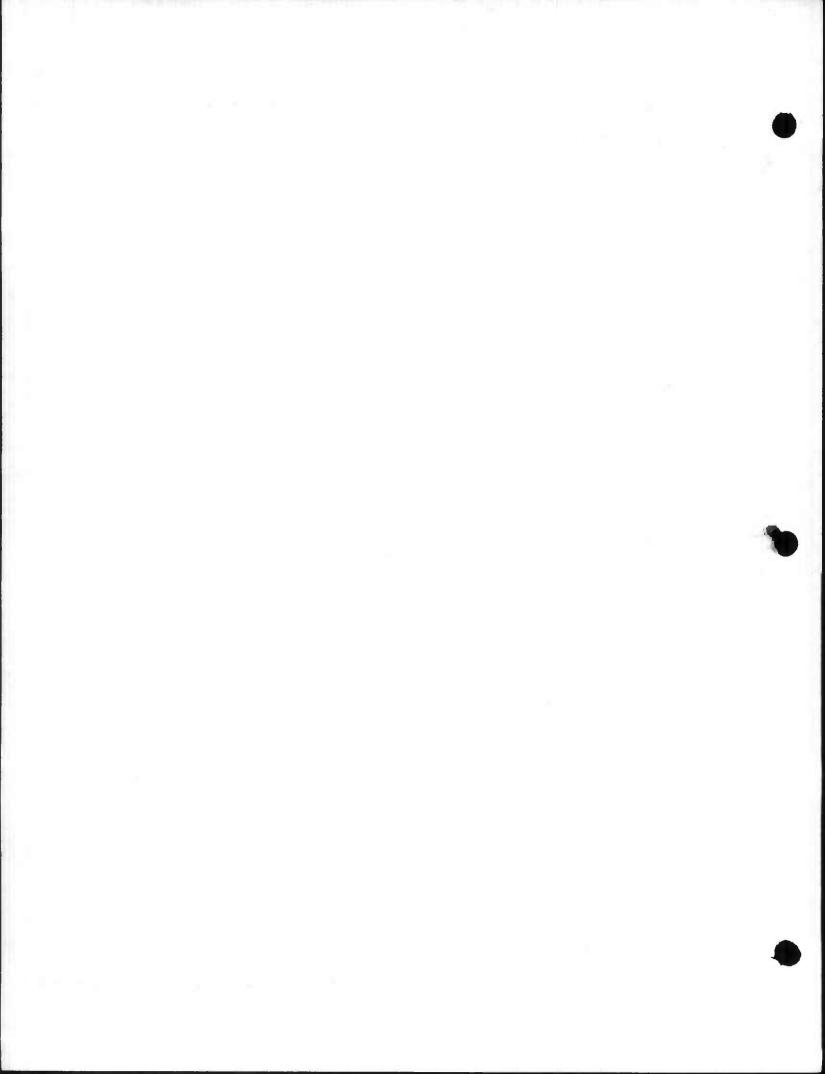
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)	Examir	ner	4a. Facility Name (If not institution, MARTIN BLVD &						own, or Lo	River	BAL	of Death I I MO	RE	
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with the Maryland	la-f show lifted at	ctor	Usual Residence of Decedent 10a. State 10b. County Penna.	/ork	10c. Cit	ty, Town or		n Ro	ek			1	0d. Inside City Limit	
6.49	20 20 20 20	Director	10e. Street and Number			_	10f. Zip Code				10g. Citizen of V			
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d2sh	Thand Tism traum		19a. informant's Name/Relationship Lottie V. Ble			19b. Ma	iling Addrass (Stre		er or Run	al Route Numbe	r, City or Town,	State, Zip	Code)	
ages 1 an	ent of Health ht: If item 27 ry or other to		20a. Mathod of Disposition 1 Burial 2 Cremation 3	☐Ramoval from	State	cemetery, cr	position (Name of ematory or other p	lace)	9	Date / C / O G	20c. Location -			-
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State of Maryland / Department of Health and Mental Hygiene

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afta Dire	erti	4 ☐ Homicida determ	building,	, atc. (Specify))			City or To	wn, State)		
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		30. Neme and eddrass of person Denn's J. C. 31. Data filed (Month, Dey, Yeer)	hutemo		111	Penn S	treet,	Baltim	ore, Ma	rylan	d 2120
St Regist	ate rar) 1997 Ju	istrar's Signeti	har Ra	dall					



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month **Physician** izabeth ennie :40am narc /Medical 4a Facility Nema (If not Institution, give street end number)
Lorien Riverside Nursing & 4b City, Town, or Location of Death 4c. County of Death **Examiner** 1can 6 Rehabilitation Center
5. Social Sacurity Number 6. Sax Harford 8. Data of Birth (Month, Day, If Undar 24 Hrs. 7. Aga (In yrs. lest birthday) If Undar 1 Yaar **Funeral** Birthplece (Stata or Foraign Country) June 6,1910 Months Days Hours 1□ M 2⊠ F Min 86 Yrs. 217-20-6463 Director Pennsylvania Usual Rasidance of Dacedant with the Maryland 10b. County ral', or items 23a or 28a-f show Examiner must be notified at 10c. City. Town or Location 10d. Insida City Limits Director 1X Yas 2 No Maryland Cecil Perryville 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 101 Carter Court, Apt. D 21903 death Funeral U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? 11. Marital Status Was Dacedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amarican Indian, Black, White, atc. Peges 1 and 2 should be filed within 72 hours after ment of Healith and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or the ury or other traumatic event, I'm Medical Examina 1 Navar Marriad 2 Married 1 ☐ Yes 2XXVo if Yas, Giva Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Spacify: Completed by Specify: 3XXWidowed 4 ☐ Divorced **Black** Year or Dates: 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industri Bainbridge Naval Training Ctr. Elamantary/Secondary (0-12) Eight Years Collega (1-4or 5+) Port Deposit, Maryland Food Services 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Be Eugene S. Boyer 2 Matilda Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) pemit. Peges 1 and 2 Depertment of Health a Important: If Item 27 is any Injury or other tra Georgianna E. Booker (Daughter) 494 Booker Road, Delta, Pennsylvania 17314 20b. Pleca of Disposition (Name of cematary, cramatory or other pleca) 20a, Mathod of Disposition 20c. Location - City or Town, Stata XXBurial 2 Cremetion 3 Removal from Stata 3/8/97 4 ☐ Donation 5 ☐ Other (Spacify) Sinai Cemetery Peach Bottom, Pennsylvania 21. Signature of Funeral Sarvice License 22. Name end Addrass of Fecility Lee A. Patterson & Son Funeral Home attown, Dr. Perryville, Maryland 21903-0188 23a. Part 1. Enter the disease, or complications thet ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intarvel Batween Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Examiner The law requires that the death certificete be executed buriel-transit Sequantielly list conditions, if any, laading to immedieta ceuse. Entar Underlying Causa (Diseasa or injury that initiated avants rasulting in death) Last Dua to (or es e consaquance of): Division of Vital Records, P.O. Box 68760, Physician/Medical the Due to (or as a consaquance of) use es Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably þ ed bluods Completed 24b. Wara autopsy findings eveilebla prior to complation of causa of daath? 24a. Was an autopsy peed hes this certificate 1 Yas Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this certifica stely filled in by the funeral director, p Be 25. Was cesa rafarred to medicel 26. Placa of Death (Check only ona) axaminar? 3 No 2 Othar: 1 Yas 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) Mannar of Death Certification: Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending Investigation 1 Yas 2 No 2 Accident 3 Sulcida 6 Could not be daterminad 28a. Place of Injury - At homa, farm, straet, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida To the Hospital within 24 hours e Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennar es stated.

Medical Examiner: On the basis of exeminetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certified 29b. Signation re and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar

31. Data filad (Month, Day, Year)
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30. Nama and address of person will

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32. Registrar's Signatura

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State of Maryland / Department of Health and Mental Hygiene

				·		tificate of		, ,	g. No.	7 08	199				
1	Physici	an	1. Decedant's Nama (First, Middla, Last)	1			2. Data of Death Month	Day	Yaar	na of Death				
М	/Media	al	PATRICIA	D.	BLA		4h Chi Taun and as	FEBUA!			:20 AM				
	Examir	er	4e. Fecility Neme (If not institution, give 5014 HOLLYWOOD				4b. City, Town, or Loc COLLEGE		4c. County	of Deeth E GEORO	2FC				
-	Funeral		5. Social Security Number 6. Sa	x 7. Aga (In yrs. i	last birthday)	If Under 1 Year				9. Birthptace (Str					
13	Director		5 79- 74- 4/28 10 Usual Rasidance of Decedent	M 21XF 43	Yrs.	Months Days	Hours Min.	8. Dete of Birth Mogth, Day, 2/7/54	Year)	WASHINGT	ON, DC				
	with the Maryland a or 28a-f show be notified at	tor	10e. State 10b. County MD		y, Town or Loc DLLEGE						da City Limits Yes 2 No				
	th with the 23a or 28 ast be not	al Director	10e. Straat and Number 5014 HOLLYWOOD I	ROAD		10f. Zip Coda 20746)	10	og. Citizan of What Country? USA						
020	72 hours after dea netural", or items dical Examiner m	by Funeral	11. Maritel Stetus SINGLE 1 Never Married 2 Married 3 Widowad 4 Divorced	12. Wes Decedant Evar in U, Armed Forcas? 1 ☐ Yas ※XNo If Yas, Giva Year or Dates:		Vas Decedant of F Yes, specify Cub ☐ Yas XXNo	Hispanic Origin? (Spean, Maxicen, Puarto F Specify:	cify Yes or No- lican, atc.)		e - Amaricen Indis k, Whita, atc. BLACK	n,				
Maryland 21215-0020		Completed	15. Decedant's Edu (Specify only highast grad Elemantery/Secondery (0-12)	cetion e com <i>plated)</i> College (1-4or 5+)	16a. Daced (Giva k lifa. D	ent's Usual Occup kind of work dona OO NOT usa ratire	petion during most of workin d)	9		sinass/Industry					
2	tal Hygiere. d other than event, the M	Con	12 YEARS	4 YEARS	GRAPH	IIC DESI	LGNER		DESIG						
and		Be	17. Father's Nama (First, Middla, Last) CHARLES B. B.	(ACK			18. Mothar's Nama ETHEL R		feidan Sumam	dan Sumama)					
7	and Me and Me a mark numatio	10	19a. Informant's Name/Ralationship (7)		19b. Mailine	a Address (Street	and Number or Rural		City or Town.	Stete. Zip Coda)					
	1 To 1 To 1 To 1 To 1 To 1 To 1 To 1 To		ETHEL R. BLACK	p=1,	5	306 EAS	ren avenue	., DC	20011	, _,,					
Baltimore,	85= 5		20a. Mathod of Disposition 1 □ Buriel 2 □ Cremetion 3 □ F 4 □ Donation 5 □ Othar (Specify)	Iamoval from State	a <i>matary</i> , cram	ition (Nama of atory or other pla TAN CREM				City or Town, Stat	a				
Balti	permit. Pa Department Important: any injury once.	5	21. Signeture of Funeral Service Licens	22. Nama and Address of Facility T. RHINES CO., INC. 3030 12TH ST NE, DC 20017											
	OTHER)		23a. Par V. Entar the disaasa, or compi	ications that caused the death	n. Do not anta	r tha moda of dyl					lmeta Between				
	Physician /Medical Examiner	er	Immadiata Causa (Final diseasa or condition resulting in death)	Ea F	ty L	iver				Onsat a	and Death				
K 68760,	ortificate be executed ing physician and e as the burial-transit	8													
Box	eath certific attending I	lan/		J											
P.O.	es that the de igned by the a be detached	Physician/N	Part II. Other significant conditions cor	tributing to death but not resu	ulting in the un	derlying causa gi	ven in Part I.			ntribute to the cau					
	s that med b	by P						1 4	98 212(NO	3 Probably	4 Unknown				
Vital Records,	aw requii 1s been s 2 should	Completed						24e. Wes en perform	ned?	24b. Wara eutor evailabla pr complation of daath?	rior to				
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Vita	iclan: The certificate rector, pag	Be	25. Was cese refarred to medicet axaminar? ¼ Yas 2 □ No	lospital:		Ott	26. Placa of Death								
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Division	or Attendation of the Control of the	Certification:	3 Suicida 6 Could not be determined	28a. Place of Injury - At ho building, atc. (Specify	ome, farm, stre	at, fectory, office	2	8f. Location (St. City or Town		er or Rural Routa	Number,				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical C		sicisn: To the best of my knowner: On the basis of examinet and manner stated.							ise(s)				
	To the within 2 To the comple	Me	29b. Signature end titla of certifiar			29c. Licans	sa number	29	d. Data signed	(Month, Day, Ye	ar)				
	(2)		Att A 30. Neme and eddress of person who co	wholeted causa of death (trem	9, MX 23e) (Type, F	O.C	.M.E.	F	EBUARY	28,19	97				
	Sta	te	Stephen S. Ra 31. Data filed (Month, Day, Year)		Ponn	Stroot	, Baltim	ore, M	aryla	nd 2120	1				
	Registr	ar	MAR 03 1997	July Bludes	rhadall										

State of Maryland / Department of Health and Mental Hygiene

						Certificate of	of Death	R	eg. No.	37 0	18200		
П	Physic	lan	1. Decedent's Name (First, Middle, L		00.100	,		2. Dete of Dea Month		Year	3. Time of Death		
J	/Medi		WALTER S					FEBRUA		1997	FOUND		
2	Examlı	ner		AVENU	E		TAKOMA	PARK		of Death E G EOI	rges		
	Funeral Director		195-20-5127	Sex 7. A	ge (In yrs. lest bi	Yrs. If Under 1 Ye Months Da		8. Dele of Birth (Month, Dey June 13	Year) 3,1928	9. Birthplece Country) Pennsy	e (Stete or Foreign Lvania		
	and w		Usual Residence of Decedent 10a. State 10b. County		10c, City, Toy	vn or Location				10d	Inside City Limits		
	ith the Marylar or 28a-f ehow	ector	District of Co	umbia		Vashington					1 Yes 2□No		
	ath with t	Funeral Director	3700 North Cap				20317		Og. Citizen of V				
21215-0020	n 72 hours effer death with the Maryland "naturel", or items 23a or 28a-f show solical Examiner must be notified at	P	Never Married 2 ☐ Married Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces 1. Yes 2 If Yes, Give Year or Dates:	Ever in U,S. No June : Jan.196	13. Was Decedent	of Hispanic Origin? (Spudan, Mexican, Puerti No Specify:	pecify Yes or No- p Ricen, etc.)	14. Rac Blac Specify	ce - American I ck, White, etc.			
5-0		Completed	15. Decedent's 8 (Specify only highest g	ducation rede completed)	16a	. Decedent's Usual Oc (Give kind of work do	ne during most of wor	king	try				
121		dm	Eiementary/Secondary (0-12)	College (1-4or	5+)	ille. DO NOTuse re Professiona	tired)		A semes				
d 2	be filed withintal Hygiene. Ind other than		n/a 17. Father's Name (First, Middle, Las	t)		Toressiona		ne (First, Middle, I	United		Allily		
Maryland	ed la bo	To Be	Joseph	7	Bryski		Franc		viologii ogiilgii	Bronic	cki		
ary	Should Man	-	19a. Informant's Neme/Relationship	(Type, Print)	19	b. Melling Address (Str	reet end Number or Ru	ral Route Number	, City or Town,	Stete, Zip Co	ode)		
	5 = 2 T		Matthew A. Hinton	n(Mortuary	Officer	King Heal 3700 Nort	th Center/	US Sold: Street.	lers & .	Airmens	s Home 20317		
ore	of He		20a. Method of Disposition 1 □ Burial 2 🛣 Cremation 3	70	20b. Piace	of Disposition (Neme of ery, cremetory or other	plece) Feb. 27	1 Pate	20c. Location -	City or Town,	State		
Ē	nit. Peges ertment of h ortant: If ite injury or of		4 □ Donation 5 □ Other (Spec			apeake Crem			Beltsvi	lle,Ma	ryland		
Baltimore,	permit. Peges 1 as Department of Hea Important: If Item: any Injury or othe once.		21. Signeture of Funerei Service Lice	ine III			dress of Facility La						
	_		23a. Part1. Enter the disease, of cor shock, or heart failure. List only	nplications that cause	d the deeth. Do		_			Ap	proximele		
	Physician		SHOCK, OF HEART FAILURE. EIST OFF	one cause on each	me.						ervai Between nset and Death		
7	/Medical Examiner		Immediate Cause (Fine) disease or condition resulting in death) a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE										
П	LAdillilei	Due to (or as a consequence of):											
_	pet usit	Examiner		b. ————									
,	execun n end al-tra	Exar	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury		Due to (or es a consequence of):								
68760,	icate be executed physician end s the burial-transit		that initiated events	cDue to (or as a consequence of):									
Box 68	E 0 6	n/Medical	resulting in death) Last										
	deeth cer e attendir id for use	sicia	Part II. Other significant conditions	contributing to death t	out not resulting	in the underlying cause	given in Part I	23b Did to	phacco use co	ntribute to the	e cause of death?		
P.0	res that the de signed by the a be detached to	y Physician/		oothing to double	or not reconning	in the disconying occase	given arrate.	12(Y		3 Probab			
of Vital Records,	v requires been sign should be	ed by						24e. Wes e	n autopsy		eutopsy findings		
00	> 20	oleto						perfor	med?	compi	ble prior to letion of cause ath?		
R	0 - 0	Completed						1 🗆 Y	es 2 No	1 🗆 Ye			
ita		BeC	25. Was case referred to medicel				26. Place of Dea	th (Check only or			20110		
<u>></u>	500	To	examiner? 1 Yes 2 No	Hospitel: 1 ☐ Inpati	enl 2 ER/O	utpatient 3 DOA	Other:	ome 5 Reside	ENUS	er (Specify)			
n c	tending Phileath.	.: 0	27. Menner of Death 1 ANaturel 5 ☐ Pending	28a. Date of Inju (Month, De	y Year) 28b.	Time of 28c. Injury	njury at Work?	28d. Describe he	ow Injury occur	red			
Sio	Attending or death.	cati	2 Accident investigation 3 Suicide 6 Could not	on on			I ☐ Yes 2 ☐ No						
Division	or At efter of Direction by	Certification:	4 Homicide determined	≀ ≥56. Place of in	jury - At home, fa c. <i>(Specify)</i>	arm, street, factory, offi	ce	28f. Locetion (Si City or Town	treet end Numb n, Stete)	er or Rurel Ro	oute Number,		
_	To the Hospital or Attent within 24 hours effer deat To the Funeral Director: completely filled in by the		29a. Certifier 1□ Certifying P	hvalcian: To the best	of my knowledge	e, deeth occurred at the	e time, date end place	and due to the c	ause(s) end ma	anner as state	d		
	n 24 h	edical	(Check only one) Madical Exa	miner: On the basis of end manner of	f examinetion ar	nd/er Investigation, in m	y opinion, death occur	red et the time, d	ete and place,	end due to the	ceuse(s)		
	To the vithin 2 To the comple	M	29b. Signature and tale of certifier	10/2/	11/4-	29c, Lio	ense number	CAMULT?	9d. Date signe	d (Month, Dey	, Year)		
			PETUTY MEDICAL EXAMINER FEBRUARY 26, 199								1997		
			30. Name end eddress of person who completed cause of death (Item 234) (Type, Print)										
				-UE JR. N		11 HOSPITAL	- DRIVE, C	HEVERL	1 MAR	YLAND	20785		
	Sta		31. Date filed (Month, Dey, Year) MAR 04. 1997	32. Regist	rar's Signature	A			,				
	Registr	ar	111HL 03. 193	YELVER OUT	THE POPULATION	Hall							

DHMH 16 Rav 6/95

State of Maryland / Department of Health and Mental Hygiene 3 1/2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician EMORY** BLACK, JR. 28, FEB 1997 6:52 A.M. /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE HOSPITAL CENTER PRINCE GEORGES CHEVERLY 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 6. Sex 2 M 2 □ F If Under 1 Yeer Birthpiace (State or Foreign Country) Funeral 7. Age (In yrs. lest birthday) Months Days Yrs 577-76-8258 Director 40 JUL 23, 1956 Maryland Usual Residenca of Decedant the Maryland 10a State 10b. County 10c. City, Town or Location show 10d. Inside City Limits must be notified at Yes 2 No Director 288-4 Prince Georges Maryland Capitol Heights 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 701 Iona Terrace, natural, or items 23a 20743 United States 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2X No
If Yes, Give
Year or Dates: filed within 72 hours after Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: py Specify: 3 Widowed 4 Divorced BLACK Be Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) The Medical 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elementery/Secondary (0-12) College (1-4or 5+) SHEETMETAL WORK PRIVATE 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Pages 1 and 2 should be sent of Health and Mental marked c EMORY BLACK, SR. BETTY STOREY 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Department of Health and Important: If Itsm 27 is m any injury or other traum BETTY HUNTER (mother) 701 Iona Terrace, Capitol Heights, Md. 20743 Saltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State METROPOLITAN CREMATORY 4 Donation 5 Other (Specify) 3/8/97 ALEXANDRIA, VA 22. Name and Address of Facility ALEXANDER S. POPE FUNERAL HOMES M859 5538 Marlboro Pike, Forestville, Md. 20747 23a. Part1. Enter the disease, or exshock, or haart failure. List ch plications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, one ause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Causa (Final Cavitary Lung Disease diseese or condition rasulting in death) Examiner Physician/Medical Examiner 14 cobacterium The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if any, laading to Immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last P.O. Box 68760, Acquired 1 mmunodeticiency Due to (or as e consequenca of) for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? the 3 1 Yes 2 No 3 Probably 4 Linkhown Syndrome Records, ò 8 Completed page 2 should 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of daath? certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: Be 25. Was case referred to medical 26. Place of Daath (Check only ona) 10 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ulmpatient 2 ER/Outpatient 3 DOA epital or Attending Phys nours effer deeth. neral Director: Affer this y filled in by the funeral di After this 27. Manner of Death 28c. Injury at Work? Certification: Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1. Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide To the Hospital o within 24 hours of To the Funeral D' completely filled i 12 Certifying Physician: To the best of my knowledga, daath occurred at tha time, date and place, and dua to the cause(s) and mannar as statad.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at tha tima, date and placa, and due to tha cause(s) and mannar stated. Medical 29a, Certifian 29b. Signatura and title of certifiar 29c. License number 29d. Date signed (Month, Dey, Year) Dixa Webbert D46518

State Registrar 31. Date filed (Month, Dey, Year)

MAR 04 1997

30. Name and address of parson who complated cause of death (itam 23a) (Type, Print)

32 Registrar's Signature

PRINCE Georges

Hispital Ctn 3001 Hospital Dr.

advisor of the same of the sam

ALC: A CONTRACT DESCRIPTION OF THE PROPERTY OF

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State of Maryland / Department of Health and Mental Hygiene

	-							Death		H	g. No.	21	0020
ysici	an	Decedent's Name (First, Michael Control of the								. Data of Deat Month	Dav	Yaar	3. Time of Death
Medic		Genevieve Lo								Februar	y 28,	1997	11:09 I
camin	er	4a. Facility Name (If not institut	ion, give street and	d number)				4b. City, Town	, or Loca	tion of Death	4c. County	of Death	
		Solomans Nurs						Soloman			Calv		
neral ctor		5. Social Security Number 325-20-2962 Usual Residence of Decedent	6. Sax 1 ☐ M 2 🔀		rs. last birthda) Yrs.	Months	Days		Min.	Date of Birth (Month, Day, Dec. 16	late of Birth Month, Day, Year) 9. Birthplace (State or I Country) 111inois		
**		10a. Stete 10b. Coun	ty	10c. (City, Town or L	Location						1	Od. Inside City Llm
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9	Bec	17. Father's Name (First, Middle	e, Last)					18. Mother's	Name (/	First, Middle, N			
satic e	TOE	Walter Parker						Anne M	lcLea	ın			
Sun		19a. Informent's Name/Reletion	nship (Type, Print)		19b. Mail	ling Addres	s (Street	and Number o	r Rural F	Route Number,	City or Town,	State, Zip	Code)
4		Alan R. Billi	ngs - Soi	n				ourt, P					
eg.		20a. Method of Disposition		20b.	Place of Disp cemetery, cre						Oc. Location -		
7 04		1 ☐ Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (OIII State					02/0	06/07	4.1	1 .	
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DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 01:33 A.M. JAMES 02, 1997 BROWN 巨. MARCH 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** PRINCE GEORGE'S HOSPITAL CENTER CHEVERLY PRINCE GEORGES if Under 24 Hrs. If Under 1 Year Months Devs Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) 72 577-32-3262 Washington DC Usuel Residenca of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Prince George's Landover 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 2019 Ray Leonard Road 20785 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No 10/12/45 1 Yes, Give Yes or Detes: 12/23/48 13. Was Decedent of Hispenic Origin? (Specify Yes or No-Hispenic Origin? (Specify Yes or No-Hispenic Origin?) 14. Was Decedent of Hispenic Origin? (Specify Yes or No-Hispenic Origin?) 13. Was Decedent of Hispenic Origin? (Specify Yes or No-Hispenic Origin?) 14. Was Decedent of Hispenic Origin? (Specify Yes or No-Hispenic Origin?) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Merried by Specify: Black 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Private 7th Construction Worker 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surneme) Richard Brown Ethel Marshall 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Sadie Brown/Wife 2019 Ray Leonard Road, Landover, Maryland 20785 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removal from State Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 3/7/97 Beltsville, Maryland 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility J.B. Jenkins Funeral Home A. Persentie Nam 7474 Landover Road, Landover, Mary land 20785 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate shock, or heart feiture. List only one cause on each line. Immediete Ceuse (Finel . HYPERTENSIVE ARTERIOSCUEROTIC CARPIOVASCULAR PISEASE disease or condition resulting in deeth) Due to (or es e consequence of): Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initioted events resulting in death) Lest Due to (or es e consequence of) Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown DIABETES MELLITUS 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending 1 Yes 2 No 2 Accident Investigation

Physician /Medical Examiner

Physician

Funeral

Director

28a-f

b must be

Items 23a

'natural', or

Hygiene.

marked

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permit Pages 1 and 2: Department of Health as Important; if New 27 is any Injury or other trax other

Pages 1 and 2 should be filed within sent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

/Medical

Examiner physician and the burial-tran Physician/Medical 2 þ Completed Be Certification: To

The law requires that the death certificate be executed P.O. Box 68760, signed b Records, Division of Vital Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifice ately filled in by the funeral director, t To the Hospital within 24 hours a To the Funeral C complately filled in

State Registrar

Medical

29b. Signature and title of cartifier

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated.

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number DEPUTY MEDICAL EXAMINER

0 33954

29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

30. Name and address of person who completed cause of death frem 23e) (Type, Print) F. GOLLE JR. M.40 MARIO

3001 HOSPITAL DRIVE, CHEVERLY MARYLAND 20785

MARCH 03, 1997

31. Dete filed (Month, Dey, Yeer)

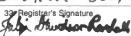
3 ☐ Suicide

29a. Certifier

4 Homicide

MAR 06 1997

6 Could not be determined



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Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

				State of	Maryland		tificate of	ieaith and iv Death	nentai Hy	Reg. No.	97 (08204			
	Physici	an	1. Decedent's Neme (First, Middle,	Last)					2. Date of De	eth	Year	3. Time of Death			
	/Medic		JOSEPH	HENRY	BELT				March		1997	3:30 PM			
4	Examir	ner	4a. Facility Nema (If not institution, § 800 Quade		per)			Forest H			ty of Death ICE Geo	orge's			
-	Funeral				Age (fn yrs. le	st birthday)	If Under 1 Yeer	If Under 24 Hrs.				ice (Stete or Foreign			
-	Director		577-44-1727	1 X M 2□ F	63	Yrs.	Months Deys	Hours Min.	05 09	1933	Mary	and			
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	with the Marylar a or 28a-f show be notified at	Director	10a. Street and Number				10f. Zip Code			10g. Citizen o	What Countr	y?			
	25a c	ralD	800 Quade Stree	et			20745			U.S.	A.				
020	within 72 hours after death with the Maryla ere. then "natural", or items 23s or 28s-f show he Medical Examiner must be notified at	by Funeral	11. Maritei Stetus 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceded Armed Force 1 X Yes 2 If Yes, Give Year or Date	es? □ No		/es Decedent of H Yes, specify Cube ☐ Yes 2 🗓 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ace - Americar ack, White, et ify: Blac	ic.			
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12	s within lone. Them	Completed	Elementery/Secondary (0-12) 8th	College (1-4	or 5+)		o <i>not</i> use retired iver	1)							
9	Hygin other ent, I	Be Co	17. Father's Name (First, Middle, La	st)			1701	18. Mother's Nem	e (First, Middle		nment				
/ar	uid be Aental rhed o filc eve	ToB	Henry Belt					Lucy F	rankli	n					
Aan	2 sho and & is mar		19a. Informant's Neme/Relationship					and Number or Run							
e,	l and lealth m 27 fhar tr		Pauline Haggins	/Niece	20h Pla		uade Str	eet, Fore		-					
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed. Department of Health and Mental Hygis Important: If itsen 27 is mented other any injury or other traumatic event, II once.		20a. Mathod of Disposition 1 ☑ Buriai 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Cei	metery, crem	atory or other place et Cemete		3/06 1997		e-City or Town				
Bal	Depart Import any in pace		Signature of Funeral Service Licensee 22. Name end Address of Facility J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 34. Parts. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate												
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P.0	The law requires that the death certivite has been signed by the attending page 2 should be deteched for use a	/ Ph	Prostate Ca	eucer					10	Yss 2□ No	3 Proba	ably 42 Unknown			
Division of Vital Records,	ulres tha n signed uld be de	d by	,							an autopsy	24b. Wer	e autopsy findings			
000	aw requin is been si 2 should	plet							perfe	ormed?	com	lable prior to pletion of cause eath?			
R		Completed							1 🗆	Yes 20 No	10	Yes 20 No			
/ita	ysician: The lav s certificate hes director, page 2	Be	25. Was case referred to medical examiner?	The state of the s				26. Place of Deat	h (Check only	one)					
of	Physic this c	To	1 Yes 2 No 27. Manne of Death			R/Outpatient		4 LJ Nursing Ho							
O	ding Phys h. After this	tlon	1 Natural 5 Panding 2 Accident Investigat		Day Year)	28b. Time of Injury	28c. Injur Wor	yat k? Yas 2□No	280. Describe	how Injury occ	med				
N S	or Attending Physician: after death. Director: After this certific. I in by the funeral director,	Ifica	3 Suicide 6 Could not	be 28e. Place of	Injury - At hon	ne, ferm, stre	et, fectory, office		28f. Location (Street and Nun	nber or Rural I	Route Number,			
Ö	5 # 5 E	Cert	4 Homicide	building	, etc. (Specity)				City or To	wn, State)					
	To the Hospital or Attenwihin 24 hours after deat Verthe Funeral Director: completely filled in by the	edical Certification:	29a. Certifier Check only one) Certifying F	Physicisn: To the beaminer: On the besi	s of examination	ledge, deeth on end/or inve	occurred et the tine estigetion, in my o	ne, date end place, pinion, death occurr	and due to the red et the time,	cause(s) and r date and piece	nanner as stat , and due to t	led. he cause(s)			
	To the com	Σ	29b. Signature and title of certifier	M			29c. Licens	e number		29d. Date eigr	ed (Month, De	ay, Year)			
7			Nawy 1	yen	M	<i>D</i>	1020	1352		2/4	175				
(0)		30. Name and address of person wh	Tien 89	of death (item	23e) (Type, P	Print) Ro	C/1070	NA	us'					
State Registrar MAR 06 1997 32. Registrar's Signeture															

DHMH 16 Rev 6/95

ELDEN BURNES

State of Maryland / Department of Health and Mental Hygiene

			or maryland	Certificate of			g. No.	08205					
/M	rsiciar ledica	JUANIA	umbad.	BowmA		2. Dete of Deeth Month	2 1997	3. Time of Death					
Exa	imine	Washington Adventist			4b. City, Town, or Lo Takoma Pa		4c. County of Deeth						
Fune Direc		5. Social Security Number 6. Sex 1 □ M 3CXF	7. Age (In yrs. lest	birthday) If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey.) March 5,	Montgo Year) 9. Birthp Cour. 1923 Vi	plece (Stete or Foreign oftry) rginia					
Di Ma		Usuel Residence of Decedent 10e. Stete 10b. County	10c. City, To	own or Location				Od. Inside City Limits					
he Mary 28a-f sho	Disotorio i	Maryland Prince George		Palmer	Park			ty∏Yes 2□No					
23a or	al City			10f. Zip Code	20785	10(10g. Citizen of What Country? USA						
0020 ours atter de raf, or items	hy Europe	3 ☐ Widowed 4 ☐ Divorced If Yes, G Year or	2 🛛 No ive	13. Was Decedent of I If Yes, specify Cub		cify Yes or No- Rican, etc.)	14. Race - American Indien, Bieck, White, etc.						
1215-0 min 72 h e. an "natur	population	15. Decedent's Education (Specify only highest grade completed Elementary/Secondery (0-12) College) (1-4or 5+)	6e. Decedent's Usuei Occup (Give kind of work done life. DO NOT use retire	pation during most of working d)	ng 16	6b. Kind of Business/Inc	dustry					
1 21 willed w tygler ther th	2	8th 17. Fether's Neme (First, Middle, Last)			Cook	1111400							
land be read of the sea of the se	P B B					eme (First, Middle, Maiden Surneme) ry Gaskins							
and M and M and M	F	19a. Informent's Neme/Relationship (Type, Print)		9b. Meiling Address (Street	and Number or Rure	Route Number, (City or Town, State, Zip						
e, R and and and and and and and and and and		Bennie Bowman/Husband		7857 Burnside									
Limore, Pages 1 a tment of Her tant: If Nem	5	20e. Method of Disposition 1		of Disposition (Name of etery, cremetory or other plea nony Memorial	Park 3	/7/97	Landover,						
Depart Depart Import	SUCE	21. Signeture of Funerel Service Licensee	ntie	J.B. Jenk	ins Funer	al Home							
Physicia /Medic Examin	eal ner	23a. Part1. Enter the dise se, or complications that shock, or heert feilure. List only one cause on Immediate Cause (Finel disease or condition resulting in deeth)	spira	oo not enter the mode of dyline consequence at	OVER KOAD	Landov- respiratory erres	er, Maryla	Approximete Interval Between Onset and Deeth					
SOX DS/DU, ath certificate be assocuted trending physician and or use as the burial-transit	1 2	Sequentially list conditions, if any, leading to immediate cause. Enfer Underlying Cause (Disease or injury that initiated events resulting In deeth) Lest Due to (or as a consequence of): ASpiration Ineumonia Iday Due to (or es e consequence of): Due to (or es e consequence of): Cancer with Melrestants											
the death centry the attending	Physician	Pert II. Other significant conditions contributing to d		acco use contribute to									
S, That is that gred be detailed	4 A	Drabetes 11	ellita	ces		1 ∐ Yss	2 No 3 Prot	ably 4 ©Onknown					
To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendir completely filled in by the tuneral director, page 2 should be deteched for use	Completed					24e. Wes en o	ed? ave	ere eutopsy findings eileble prior to mpletion of cause deeth?					
The it	Com					1 ☐ Yes	20No 10	Yes 20 No					
VICAL clan: T clan: T entificat ector, p	Be	25. Wes case referred to medical exeminer?			26. Place of Deeth	(Check only one)							
Physical chiral direction	P.	1 Yes 2 No Hospitel: 1 27. Menner of Death 28a. Dete		Outpetient 3 DOA Oth	4 LI Nursing Hon	8d. Describe how	ce 6 Other (Specify	0					
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the tuneral director,	Certification:	1 Neturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	th, Dey Year)	Injury Wor	Yes 2□No			J Paulo Mumbas					
Vital or A urs after ral Directled in b	Certi	4 Homicide build	City or Town,										
the Hosp in 24 ho the Fune	fedical		best of my knowled asls of examination of the stated.	end/or Investigation, In my o	pinion, death occurre	d et the time, dete	e and plece, end due to	the cause(s)					
5 % T P P P P P P P P P P P P P P P P P P	2	29b. Signature and title of certifier		29c. Licens D 1 9	609	3	I. Dete signed (Month, I						
15/		30. Name and eddress of person who completed cau		3503 PEKK	Y STREE	ET. MM.	RAINIE.	R. MD20713					
	State istrar	31. Dete filed (Month, Dey, Yeer) 32, MAR 06 1997.	Registrer's Signeture	Parlott									

DHMH 16 Rav 6/95

SAME TO SAME SOUNDS

After the first an about of 100 and

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08206 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Death Month **Physician** ames 99' Marc /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** mitche 2504 Kd luil eorg ec prise 16 Ince 79 5 If Undar 1 Yaar | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Jan. 15 5. Social Sacurity Number 6. Sax 7. Age (In yrs. lest birthday) 9. Birthpleca (Steta or Foreign Country) **Funeral** Months Deys Hours MM 20 F Vre 218 56 9860 42 1955 Director Maryland Usual Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits Wher than "natural", or Nema 23s or 28s-1 show ent, the Medical Examinat must be notified at 1XXVes 2□No Directo Maryland Prince George's Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20721 2504 Enterprise Road United States Funeral 14. Rece - American Indian, 12. Was Decedant Evar In U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, atc. 72 hours after 1 ☐ Yes 2XXIIIo If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas ZXNo Specify: þ 3 ☐ Widowed 4 ☐ Privorced White Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "r Air Conditioning & Elementery/Secondery (0-12) College (1-4or 5+) Steamfitter Refrigeration 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumema) Be Walter Duane Blachowske Lorraine Voosen 2 19e. Informant's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Lorraine Blachowske Mother 2504 Enterprise Rd. Mitchellville Md. 20721 20a. Method of Disposition
1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 20b. Piece of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 8 Lakemont Memorial Gardens 3/8/97 Davidsonville Md. 4 ☐ Donetion 5 ☐ Other (Specify) of Funeral Service Lie 22. Nama and Address of Facility Robert E. Evans Funeral Home, Inc. Pert1. Enter the disease, or complications that caused the death. Do not enter shock, or heart feilure. List only one ceuse on each line. 16000 Annapolis Rd. Bowie Md. 20715 Approximate Interval Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Finel disaesa or condition resulting in death) Examiner Examiner physician and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immadiate causa. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Last ronic Cirrhosis Division of Vital Records, P.O. Box 68760, Physician/Medical the Due to (or es a consequance of) attending p signed by the a Part ff. Other significant conditions contributing to death but not resulting in the undarlying causa givan in Part I. 23b. Dfd tobacco usa contributa to the cause of death? 1 | Yas 2 No 3 □ Probably 4 □ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed peed has page 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death. director. Be 25. Was case referred to medical exeminer? 28. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Menner of Deeth 28e. Dete of Injury (Month, Dev Year) 28d. Describe how Injury occurred Certification: 28b. Tima of Injury 28c. Injury et Work? 1 Neturei 5 Pending 1 ☐ Yes 2 ☐ No investigetion after death Director: / d in by the f 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Funeral Di etaly filled in 29e. Certifier Medical 11 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. completaly (Check only one) 2 Medical Examiner: On the basis of axamination end/or invastigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29b. Signature and title of Cortifier 29c. License number 29d. Dete signed (Month, Day, Year) M.D. 034722

State Registrar 31. Dete filed (Month, Dey, Year)

MAR 06 195

30. Nerse end eddres

32 Registrar's Signature

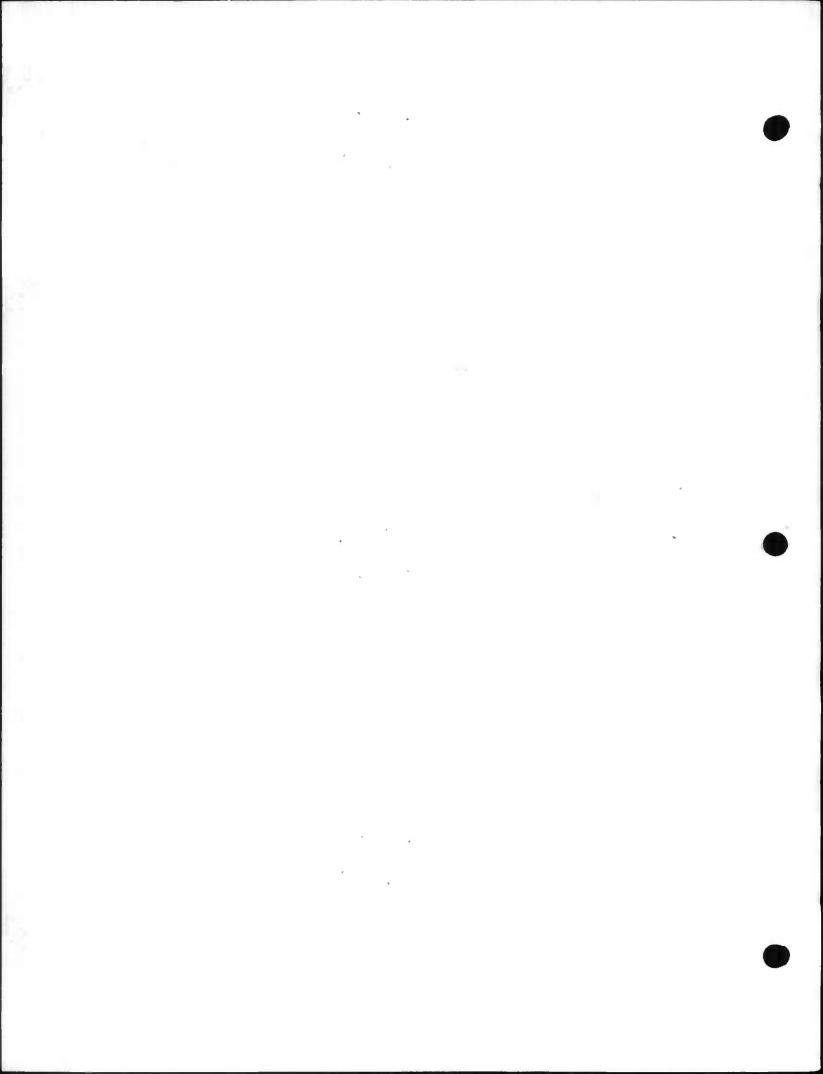
anmerpolis Rd. Bladensburg Md

of person who completed cause of deeth (Item 23a) (Type, Print)

		Decedent's Name (First, Middle, Last	st)		Cer	tificate	or De	atn	2. Date of De	Reg. No.	97	3. Time of Dea	
Physici /Medic		Herschal Orville		fu1					Month	4 P99 7	Yaar	2:30 pm	
Examir		4a. Facility Nama (If not institution, give 9033 Volta Stre		r)				ity, Town, or i	Location of Deat	4c. Count		rge's	
Funeral Director		5. Social Security Number 218 58 5765	ex 7. A		ast birthday) Yrs.	If Under 1 Y Months D		Under 24 Hrs. ours Min.	8. Date of Bi	th ² 953	9. Birthpl Barry	aca (State or For	
ž ==		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation			10d. Insida City Limits				
28a-f ehow	tor	Maryland Prince (George's	Lank	nam							MY Yes 2□	
23e or 28e-f ehov	ai Direc	10e. Street and Number 9033 Volta Street	et			10f. Zip Co 2070			10g. Citizen of What Country United States				
or items	by Funeral Director	11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedan Armed Forces 1 Yes 2 the Yes, Give Yaar or Datas	? No	,	Vas Decedent Yes, spacify		nic Origin? (S lexican, Puart pecify:	pecify Yas or No o Rican, etc.)	14. Ra Bla Specii	ce - Amarica ck, Whita, a Blac	itc.	
1 44	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation da com <i>pleted)</i> College (1-4or	5+)	(Give I	ent's Usual O kind of work d OO NOT use n Driver	one durin etired)	g most of wor	rking	16b. Kind of B			
7,	To Be Co	17. Father's Name (First, Middle, Last) Orville Brightful	 L			222701	18.		me (First, Middle Jenkin		na)		
ath and Mentel F 27 is marked of r treumatic ever	-	19a. Informant'a Name/Relationship (7 Paulette Smith Bi	ype, Print)		19b. Meilin 9033 T	g Address (Si Volta S	reet and	Num <i>ber or Ru</i> t Lan	ham, Ma	er, City or Town	, State, Zip 20706	Code)	
Department of Health ar Important: If Item 27 is any injury or other trau		20a. Method of Disposition 20b. Placa of Disposition (Nama of camatery, crematory or other place) 20b. Placa of Disposition (Nama of camatery, crematory or other place) 3/7/97 20c. Location - City or Town, Search of Disposition (Nama of camatery, crematory or other place) 3/7/97											
Department of Important: If any injury or once.		21. Signature of Funaral Service Licensee 22. Nama and Address of Facility 5538 Mar1boro Pike Pope Funeral Homes-Forestville, Maryland											
ysician Medical caminer	er	Immediate Cause (Final disease or condition resulting in death)	a. He	pate bue to (or	as a consequ	lular	E(parc	incr	70		Onsat and Death	
physician and streets the buriel-trensit	edical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that intiliated events resulting in death) Last b. Due to (or as a consequenca of): c. Due to (or as a consequenca of):											
0 0			d										
by the	Physician/M	Part II. Other significant conditions of	e given in	Part i.		Did tobacco use contributa to the cau							
hes been signed ge 2 should be del	Completed by								24a. Was	an autopsy ormed?	ava	re autopsy finding ilable prior to apletion of cause eath?	
pa	Com								10	Yes 2XNo	10	Yes 2□ No	
certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital:		-5/0	-C -	Other		th (Check only				
within 24 hours effer death. To the Funerel Director: Affer this certific completely filled in by the funeral director,	ation: To	27. Menner of Deeth 1. Natural 5 Pending 2 Accident investigation	1 ☐ Inpati 28a. Date of Inj (Month, Da	urv	ER/Outpatient 28b. Time of Injury	28c.	Injury et Work? 1 Yes		Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred)	
s ofter death.	Certification:	3 Suicide 6 Could not be determined	289. Placa of In	jury - At hor tc. (Specify)	me, farm, stre	et, factory, of	fice		28f. Location (City or To	Street and Numi wn, State)	ber or Rural	Route Number,	
within 24 hours a To the Funeral I completely filled	edicai	29e. Certifier (Check only one) Certifying Phy 2 Medical Exam	raician: To the best iner: On the basis of and manner a	of examination	riedge, death on and/or inve	occurred et the estigation, In r	ie time, d ny opinio	ete and piace n, death occu	, and due to the rred at the time,	cause(s) and m dete end pleca,	anner as sta and due to	ited. the causa(s)	
To th comp	Me	29b. Signature and title of cartifier	Donn	0 (m	29c. Lie	ense nui	nber		29d. Date signe	d (Month, D	Pay, Year)	
William I		30. Name and address of person who d	ompleted cause of	death (Item	23a) (Type, F	Print)	70	13 T		2101	//		

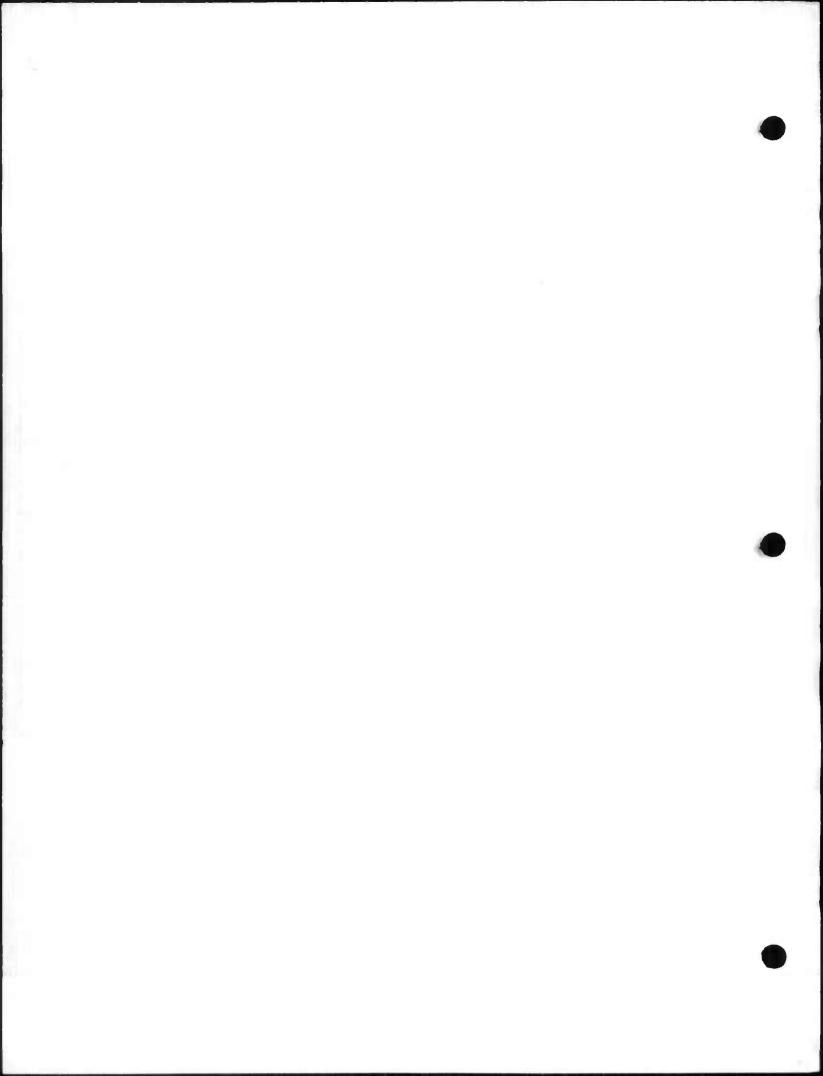
DHMH 16 Rev 6/95

	FOR 1 - STATE REGISTRAR	STATE OF M		D / DEPAR					MENTA	L HYGIEN	_	,	00200
	1. DECEDENT'S NAME (First, Middle, Lest) Rodney Webster B	durns Sr			,		02/11		2. DATE	OF DEATH	AY	YEAR	3. TIME OF BEATH
	4. SOCIAL SECURITY NUMBER 210-30-1146	5. SEX 15 M 2 F	_	s. Inst birthday) YRS.	IF UNDER	1 YEAR	IF UNDER	24 HRS. MIN.	(Monti	OF BIFTIN	902	Countr	PLACE (State or Foreign Vland
ron	9a. FACILITY NAME (If not institution, give so 21501 West Liber					arkt	on Locatio	ON OF D			9c. COUN	timo	EATN
DIRECTOR	10s. STATE 10b. COUNTY	imore	_	10c. CIT	y, town o Park		TION						10d. INSIDE CITY LIMITS? 1 □ YES 2 ☑X80
FUNERAL	21501 W. Liberty	Road				101	. ZIP CODE	21	120		US.		WHAT COUNTRY?
BY	11. MARITAL STATUS 1 Never Married 2 Married \$\times \times 12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2	821940		If yes, sp	ENDENT Of Cuber 2 XXV	n, Mexica	in, Puerto I	17 (Specify Yes Rican, etc.)	or No-	14. RACE Black Speci	- American Indian, t, White, etc.	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Coflege (1-4 or 5 +) 16a. DECEDENT'S USUAL OCCUPATION (Clive kind of work done during most of working kills. Do NOT use retired.)										SINESS/IND			
COMPLET	6 Farmer Dairy Farm 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname)												
Thomas R. Burns 18. Mother's Name (First, Middle, Lest) Thomas R. Burns Jennie A. Barshinger													
19a. INFORMANT'S NAME (Type/Print) Rodney W. Burns, Jr. 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21715 W. Liberty Road, Parkton, Md. 21120											.20		
	20s. METHOD OF DISPOSITION \$\times Burial 2 \subseteq Cremation 3 \subseteq Remote Proceedings of the Control of the Co		20b.PL/ certetory STE	ACE AND DATE	ther place)	Ceme	etery		3/12/	9 Ster	warts	town	wn, State
	21. SIGNATURE OF FUNERAL SERVICE LIE	district			1	9 S.		n S	t., S	Stewar	tstow	n, P	Mortuary 2a. 17363
CATION	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	NSEQUENCE O	F):								
MEDICAL	PART II. Other significant condition	s contributing to	death but r	not resulting	in the un	derlying	g ceuse g	íven In	Part I.	24a. WAS AN PERFOR 1 YES 2	RMED?	246	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	EQ/Outnoties	m 3 □ DOA	OTHER	3:	ACE OF OE						
РНҮ	27. MANNER OF DEATN 1 Natural 5 Pending	28s. DATE OF I (Month, Da	NJURY	28b. TIN		28c. INJ	URY AT	and of the o	_	CRIBE HOW I	NJURY OCC	URED	
ED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	At home, farm,	M street, fect		YES 2] NO	281. LOC City	ATION (Street or Town, State)	end Number	or Rural F	Route Number,		
COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.) and menner as stated.	
TO BE C	296, SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WH	n m	()	DIEM ST. /Fm	· Christ	·	29c, LICE	68	MBER	6	29d. DATE	SIGNEO	(Month, Day, Year) 7 - 9 7
	5621 Long Corner	Road, Wh.	ite Ha	all, Mo	21	161							
	5621 Long Corner Road, White Hall, Md. 21161 31. DATE FILEO (Month, Day, Near) MAR 19 1997 A. REGISTBAR'S SIGNATURE WAR June Davidson—Renders												



BALTIMORE, MARYLAND 21215-0020	24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunta-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burlal, cremation, or removal.	the medical examiner must be netified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPTAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.											
7	1. DECEDENT'S NAME (First, Middle, Last) MARGARET	MAGBALE		COWL	ES	2. DATE OF DEAT		year 3. TIME OF DEATH 8000 M				
ŋ	4. SOCIAL SECURITY NUMBER 273-05-7126	1 □ M 2 🙀 F 9	yrs. last birthday) O YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN,	7. DATE OF BIRTH (Month, Day, Yes August 31	, 1906	BIRTHPLACE (State or Foreign Country) Pensylvania				
TOR	9a. FACILITY NAME (If not institution, give at 9100 16th Street RESIDENCE OF DECEDENT	reet and number)			Spring	EATH		y of DEATH JOMETY				
DIRECTOR	10a. STATE 10b. COUNTY	gomery		Silver S				10d. INSIDE CITY LIMITS? 1 YES 2 NO				
FUNERAL	9100 16th Street			100	20910		U.S.	EN OF WHAT COUNTRY?				
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATI	2 NO	If yes, sp		NIC ORIGIN? (Specifin, Puerto Rican, etc.);	.)	4. RACE — American Indian, Black, White, etc. Specify: Caucasian				
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) 1 2	CATION 1 Completed) 1 College (1-4 or 5 +)	Give kind of the Do NOT u	-	ON st of working		Home	STRY				
BE CON	17. FATHER'S NAME (First, Middle, Last) Jacob Zurfluh					ME (First, Middle, Ma Zwald	Malden Surname)					
TO E	Jeffrey E. Cowles (son) 186. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9.100 16th Street Silver spring, MD 20910											
1	20e. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Remote A Connection 5 Other (Specify)	oval from State cemete	ery, crematory or o	of Disposition (New Mither place) Geo Modica 22. NAME AI	Wash	Marrin	LOCATION — CII Washing	gton, D.C.				
	21. SIGNATURE OF FUNERAL SERVICE UD	Lerdin		Colur 225 M	nbia Mori Issouri	tuary Sei Ave. NW V	vices, Wash. D.	Inc. C. 20011				
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a.											
MEDICAL	PART II. Other significant conditions	s contributing to death but	not resulting	in the underlying	g cause given in	PEI	S AN AUTOPSY N-OPIMED?	24b. WERE AUTOPSY FINDINGS MALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: 1 ☐ Inpetient 2 ☐ ER/Outpat	lent 3 🗆 DOA	OTHER:	ACE OF DEATH (Ch	eck only one) 9 Other (Specify)						
ву РНУ	27. MANNER OF DEATH 1 Netural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	IE OF 28c. INJ		28d. DESCRIBE H		RED				
	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, etc. (Specify,	At home, farm,	street, factory, offic	•	261. LOCATION (St City or Town, S	reet and Number or Nate)	Rural Route Number,				
COMPLETED		CIAN: To the best of my knowled R: On the basis of examination a										
TO BE C	290 RIGNATURE AND TITLE OF CERTIFIER COTO OF THE STATE O	Songsto	rck	med	29c LICENSE NUI	MBER / 2 /	≥9d. DATE 5	SIGNED (Month, Day, Year)				
	George F. Sengsta	ack, M.D.		3929 Whea	Ferrara ton, MD	Drive 20906						
	31. DATE FILED (MONTH) Day, Your Service Strain Sandown - Portical San											



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	_	I Decided to the Control of the Cont		C	Pertificate	e of D	eath		Reg. No.	97	08210		
Physic	cian	Decedent's Neme (First, Middle, Landson Control of the Contro						2. Dete of De Month	Dey	Yeer	3. Time of Death		
/Med	lical	Dimetra	Athanas	Cras	ssas	41.	0'- T		5, 1997		6:50 PM		
Exam	iner	4e. Fecility Name (If not institution, gi						Location of Deat	h 4c. County	of Death			
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anyland show ad at		Usuel Residence of Decedent 10a. Steta 10b. County		10c. City, Town o	or Location					11	Od. Inside City Limits		
and and	cto	Maryland Montgom	ery	Silver	Spring						1 ☐ Yes 2X No		
E 22 B	ire	10e. Street end Number			10f. Zip	Code			10g. Citizen of V	0g. Citizen of What Country?			
23 w W	2	1031 Cresthaven	Drive			20903			USA	1			
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72 hours natural.	8	15. Decedent's E		16e. D	Decedent's Usuel Occupetion (Give kind of work done during most of work life. DO NOT use retired)				16b. Kind of Br				
Z 1 Z 1 D-UUZU d within 72 hours at piene. r than "natural", or the Medical Exam	Completed	(Specify only highest gr Elamentary/Secondery (0-12)	ede completed) College (1-4or 5+)										
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Maryland d 2 should be file th and Mental Hy 7 is marked othe traumatic event	B	17. Fether's Neme (First, Middle, Las)			1	8. Mother's Ner	ne (First, Middle	, Maiden Sumen	10)			
hould by the standard by the s	10	Christos Athanas					Zaharo	Chacon	as				
2 sh and and and and and		19e. Informent's Name/Relationship							er, City or Town,				
- 59% 5		James P. Crassas	/ Son								yland 2090:		
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St Regis	ate	31. Dete filed (Month, Dey, Yeer)	32. Registrer	Signature	1 Bandal			•	V				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death Vear **Physician** Month Rose Cimokowski Leigh February 27, 1997 10:20 PM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care - Bethesda Chevy Chase Montgomery If Under 1 Year 5. Social Security Number Birthpiece (State or Foreign Country) 7. Age (In yrs. last birthday) Dete of Birth (Month, Dey, Year) **Funeral** Days Hours 1 □ M 2 🕱 F Yrs. Director 577-01-1364 August 3,1917 North Carolina Usuai Rasidence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. inside City Limits items 23s or 28s-f show iner must be notified at 1 ☐ Yes 2 ဩ No Director Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 6604 Ian Street 20784 U.S.A 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ™ No if Yes, Give Year or Dates: 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. the Medical Examiner 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: ð Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highast grade completed) Eiementary/Secondary (0-12) Coliege (1-4or 5+) 12 Housewife Own Home 17. Fether's Name (First, Middle, Last) permit. Pages 1 and 2 ahould be file. Department of Health and Mental Hy Important: If then 27 is marked other any injury or other trisumatic event sonce. 18. Mother's Name (First, Middle, Maidan Surneme) Be George A. Fincher, Sr. Irene Bailey 19a. informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) <u>Edwin William Cimokowski</u> 6604 Ian Street Hyattsville, Maryland 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Gate of Heaven Cemetery 3/03/97Silver Spring, Maryland 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 23a. Part. Entar the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Approximete Intarval Batween Onset end Death Physician POLON CA /Medical immediate Cause (Final disease or condition rasulting in death) Examiner Examiner Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown by 24b. Ware autopsy findings evaileble prior to Completed 24a. Wes an autopsy completion of cause of death? 1 ☐ Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Placa of Death (Check only ona) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Dey Year) 27. Manne of Death 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Naturai 5 Pending Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Steta)

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Baltimore, Maryland 21215-0020

Pages 1 and 2 should be

Certification: edicai

4 ☐ Homicide

29b. Signature and Illie of

31. Date filed (Month, Day, Year)

29a, Certifiar

in by the funeral al or Attending after death. To the Hospital o within 24 hours af To the Funerel DI

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Registrar

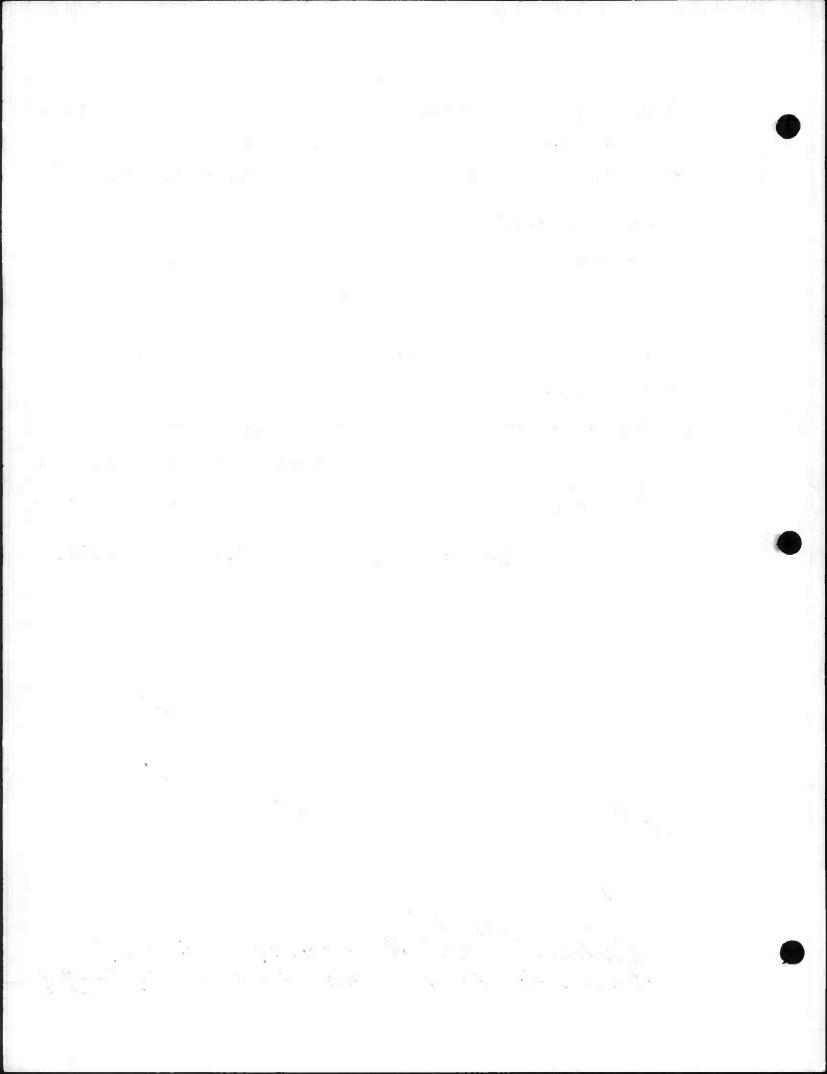
32. Registrar' Signature MAR 0 3 1997

1 Cartifying Physician: To the best of my knowladga, daath occurred at the time, dete end placa, end due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Myhth, Day, Year)

28e. Place of injury - At home, farm, street, factory, office building, atc. (Specify)



Please Type or Print in Black Indelibie Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month March 2, William J. Colligan 1997 4:06 AM /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Deeth Carriage Hill Bethesda Bethesda Montgomery 5. Sociat Security Number If Under 1 Yeer | If Under 24 Hrs. 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Massachusetts Funerai 1)X M 2□ F Months Days Hours Min. Yrs. Director 026-12-4149 71 August 8, 1925 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director Maryland 1 Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10201 Grosvenor Place #1416 20852 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Datas: WW I I thems. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 M Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 'natural', or 1 Yes 2 No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) Cotiege (1-4or 5+) Analyst C.I.A. other permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, important: if fleen Z7 is marked other any injury or other to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William J. Colligan Mary Mahoney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert D. Colligan 334 Colfax Avenue, Clifton, New Jersey 07013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Date 1 ☐ Burial 2 Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 3-3-97 Beltsville, Maryland 22. Name and Address of Fecility
Rapp Funeral Services, P.A.
933 Gist Avenue, Silver Spring, Maryland 21. Signature of Funeral Service Licensee 20910 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Pneumonia 2 months Examiner Due to (or as a consequence of): Examiner Cerebral Vascular Accident ettending physician end for use es the buriel-transit The law requires that the death certificate be executed Sequentially tist conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting to death) Lest Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medicai Due to (or as a consequence of): ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown signed to þ Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 2X No 1 Yes 1 ☐ Yes 2 No Division of Vital or Attending Physician: Be 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitat: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After 1 Naturat 5 Pending Investigation To the Hospital or Attending within 24 hours after death.

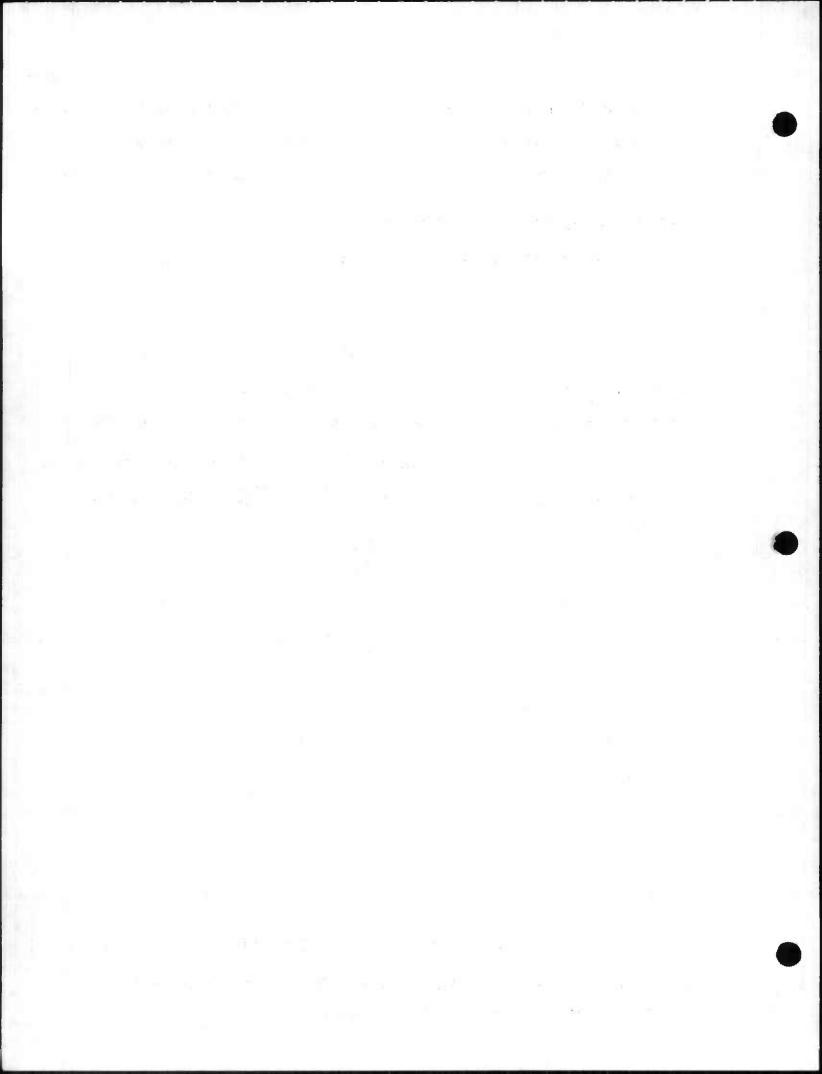
To the Funeral Director; After completely filled in by the fun 2 Accident 6 Coutd not be determined 3 ☐ Sulcide 28e. Ptace of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homictde 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Com who I 7 9 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

State Registrar John F. Tauber, M.D.
31. Date fited (Month, Day, Year)
MAR 0 5 1997

8218 Wisconsin Avenue #318, Bethesda, Maryland 20814
32. Registrar's Signature

All Davidson Fundaments



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended #8,3/14/97, JW,MC State of Maryland / Department of Health and Mental Hygiene Amended # 17, 3/14/97, JW, Montg. Cty. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** Month Louise G. Cassell March 5, 2:20 PM 1997 /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Holy Cross Hospital Silver Spring
If Under 24 Hrs. 8. Dete of Birth
Hours Min. 8. (Month, Day, Year) Montgomery 5. Social Security Number If Under 1 Yeer 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funerai** Deys 1□M 2₩F 90 Yrs. 215-01-0962 Director Mar. 6, 1906 Maryland Usuel Residence of Decedent Mar. 15 the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at 1 ☐ Yes 2 ☐ No 288-71 Directo Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? b must be Items 23a 12325 New Hampshire Avenue 20904 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, filled within 72 hours after Hygiene. (ther then "netural", or the Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Merried 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. by Specify 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Secretary Railroad marked other 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental Albert Saffner Salfner Grace Cassell 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) ä Important: If Item 27 any injury or other tr Patricia Caldwell / Half-sister 1100 Ryegate Road, Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 ₩ Burlei 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery 3/7/97 Elkridge, Maryland 22. Name end Address of Fecility Hines-Rinaldi Funeral Home 21. Signeture of Funeral Service Licenses 11800 New Hampshire Avenue Olla Silver Spring, Maryland 20904 23a. Part1. Enter the diseare, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failule. List only one cause on each line. Approximete intervai Between Onset end Deeth **Physician** /Medical Immediate Cause (Final Acute Pneumonia disease or condition resulting in deeth) 24 hours Examiner Due to (or es e consequence of): Examiner The law requires that the death certificate be executed the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 88 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 28 No 3 Probably 4 Unknown Arteriosclerotic cardiovascular disease of Vitai Records, þ 8 24b. Were eutopsy findings eveilable prior to completion of cause of death? director, page 2 should Be Completed 24e. Wes en eutopsy performed? certificate 1 Yes 21 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No this filled in by the funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After Division 5 Pending Investigation 1 X Neturel To the Hospital or Attendit within 24 hours after death. To the Funeral Director; A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of an inheritor and/or investigation, in my opinion, death occurred at the fime, date and place, and due to the cause(s) and menner stated. completely (Check only 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year)

State Registrar

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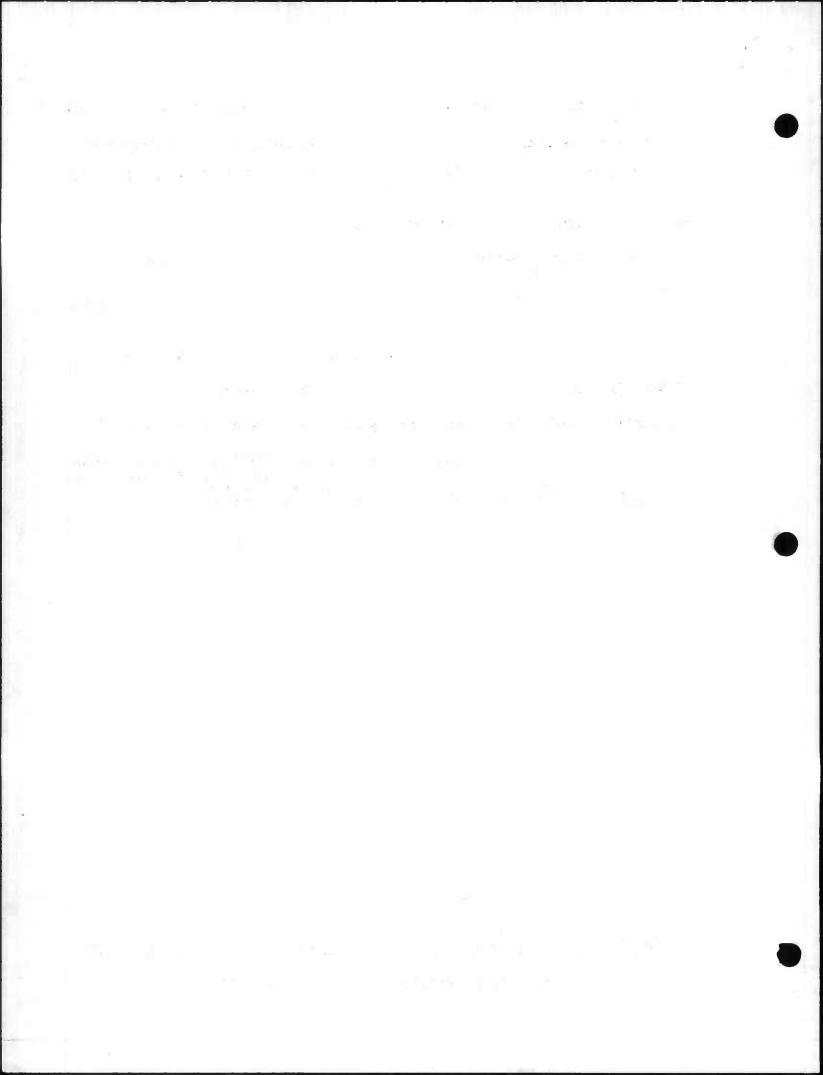
31. Defe filed (Month, Dev. Year)

30. Name end address of person who compléted cause of deeth (Item 23e) (Type, Print)



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March 5, 1997

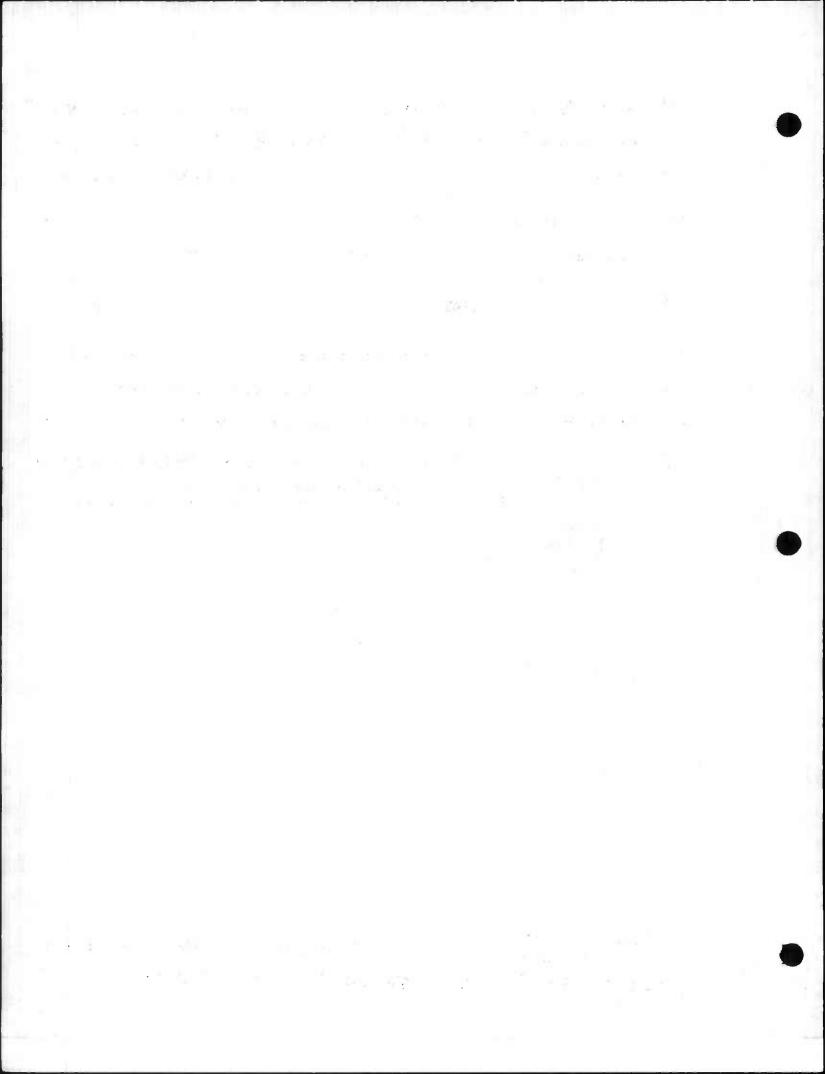


State of Maryland / Department of Health and Mental Hygiene 08214 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death **Physician** Month Yaar Cadle Horace March 1997 /Medical 4e. Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Daeth **Examiner** Roson Hos wood Laurel Prince beomes 5. Sociel Security Number If Undar 1 Yaar If Under 24 Hrs. 6. Sax 7. Aga (In yrs. last birthday) Birthpiace (State or Foreign Country) **Funeral** 11 M 2□ F Months Deys Hours Yrs. Director 214-05-1036 81 June 18,1915 Pennsylvania Usual Rasidance of Decedant The Maryland 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits must be notified at Director 1 Yas 2 No Prince George Laurel 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Items 23s 7101 Quill Lane 20707 USA Funeral 12. Was Decedant Ever in U,S. Armed Forcas? 1 (XYas 2 □ No If Yas, Giva Yaar or Detes: 1943–46 Wes Dacedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Biack, Whita, etc. 11. Maritel Status Hygiens. Oher than "natural", or itser ent, the Medical Examiner. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yas 2 XNo Spacify Completed by 3 XWidowad 4 Divorced 15. Decedant's Education (Spacify only highast grade complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Coilega (1-4or 5+) Grade 11 Disposal Engineer U.S. Government 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be Sheldon Elwood Cadle Hettie Elizabeth Collison 19a. Informant's Neme/Ralationship (Type, Print) Department of Health and Important: If Item 27 is m any injury or other traum 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Katherine M. Cadle daughter 7101 Quill Lane, Laurel, Maryland 20707 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Buriel 2 □ Crametion 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) 3/5/97 Maryland Veterans Cem. Cheltenham, Maryland 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility
Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the draws a, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiratory arrest, shock, or hear failure. List only one cause on sech line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final l week diseese or condition rasulting in daath) **Examiner** Examiner Cororon years sician and burial-transit The lew requires that the death certificete be executed Sequantially list conditions, if eny, laading to immadiata causa. Entar Undarfying Causa (Disease or injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): P.O. Box 68760, Physician/Medical the Dua to (or es e consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown hyperlipsdomi Records, þ Completed 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? complation of cause of death? 1 Yas 1 Yas No certificate Division of Vital nepital or Attending Physician: The hours efter death.
Inverse Director: After this certificate yilled in by the funeral director, pa Be 25. Was casa rafarrad to medical examinar? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No P 12 Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Death Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 3 Suicida 28a. Piace of Injury - At home, ferm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida To the Hospital o within 24 hours of To the Funeral Di completely filled is Medical time Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Cartifian 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 1997 30. Nama end eddress of person who complated causa of death (Itam 23a) (Type, Print) Drive Sk 204, land, MS Park lamel 14201 32 Registrar's Signatura 31. Data filed (Month, Day, Year)
MAR 0 5 1997

DHMH 16 Rev 6/95

State Registrar



32 Registrar's Signature

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Dey, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08216 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 3 **Physician** Conway Barbara ollard 0 /Medical 4e. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Nursing + Rehab Center Bel Forest Bel Air If Under 1 Year Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (Steta or Foreign Country) Months Deys 1□M 20 F Hours 011-09-8906 Director 01-20 Massachusetts Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City I Imits 1 Yes 2 No Director 288-41 Harford Bel Air the Medical Examiner must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 426C Moores Mill Road 21014 Herne 23s U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Yaar or Dates: 11. Marital Status Wes Dacedant of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Biack, Whita, etc. 1 Naver Marriad 2 Married 8 Baltimore, Maryland 21215-0020 1□ Yes 2 No p 3 Widowed 4 □ Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education ify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Insurance Processer Insurance pernit. Pages 1 and 2 should be find Department of Health and Mental Hygi important: If from 27 is marked other any injury or other traumatic event, Il 17. Fether's Neme (First, Middle, Last) 18. Mothar's Neme (First, Middle, Meidan Surname) Allan Pollard Alice Prebble Gibson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Straet and Number or Rurel Route Number, City or Town, Stete, Zip Code) Bruce P. Conway 518 E. Broadway Son Bel Air, Md. 21014 Pages 1.7 20e. Method of Disposition
1 ☐ Burlai 2 ☐ Cramation 3 ☐ Removal from State 20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stata 4 ☐ Donetion 5 ☐ Other (Specify) Carroll Cremation Hampstead, Maryland 21. Signeture of Funeral Service License 22. Nama and Address of Facility
Kurtz Funeral Home, P.A. Jarrettsville, Maryland 23a. Pert1. Enter the disease, or complications that caused in death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximate Interval Between Onset end Death Physiclan /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Examiner The law requires that the death certificate be executed Sequantielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Couse (Diseese or injury that initiated events rasulting In deeth) Lest and Records, P.O. Box 68760, physician Physician/Medical the attending i Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? signed by 4 Onknown 1 Yea 2 No 3 Probably þ 24b. Wera autopsy findings eveilable prior to completion of cause of deeth? Be Completed 24e. Was an eutopsy performed? page 2 cartificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, I 25. Was case refarred to medical exeminer? 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 ursing Home Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) Menper of Deeth 28e. Date of Injury (Month, Dev Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1 Neturel 2 Accident 5 Pending Investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Pieca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide edical 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner as steted.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and menner stand. (Check only one)

State Registrar 29b. Signature and tra-

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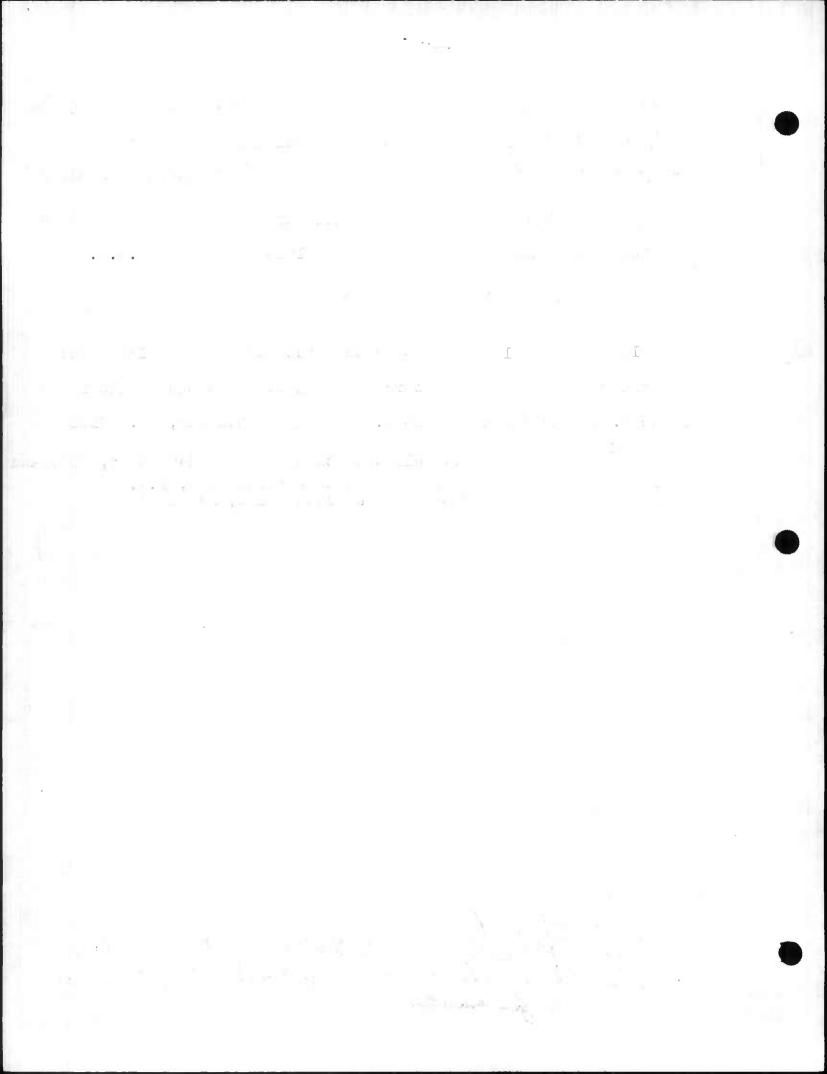
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31. Dete filed (Month, Day, Year) 99

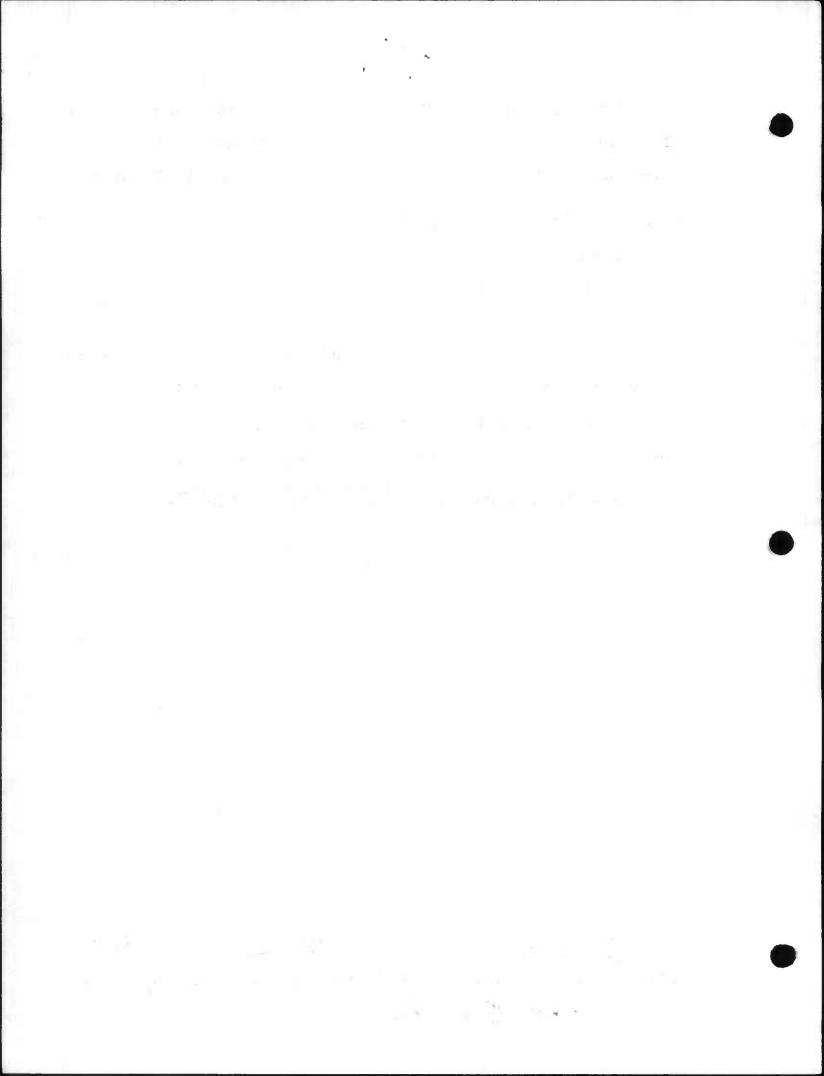
completed cause of deeth (Item 23e) (Type, Print)

29c. License number

29d. Dete signed (Month, Day, Year)



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dical Examiner		Sequentielly list conditions,	b. ———	Due to (or as e consec	quence of):								
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State of Maryland / Department of Health and Mental Hygiene

March 10, 1997 7:0 40 Fedity Name (in ori mishibition pire street and number) 4912 Dalton Street 578 - 09 - 4120 5. Social Security Number 578 - 09 - 4120 10. City, Town or Location of Death - 200 prince Ceorge's 578 - 09 - 4120 10. Street Street 578 - 09 - 4120 10. City, Town or Location of Death - 200 prince Ceorge -	Dhysiolog		1. Decedent's Neme (First, Middle, La			C			2. Dete of Dee	Reg. No. oth Day	Vest	3. Time of Deet
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106. State 106. County 107 108 108 109 1			578-09-4120	Sex 7	Age (In yrs. 78	last birthdey) Yrs.			6. Date of Birth (Month, De) Oct 11,	Year) 1918	9. Birthpl Count Nort	ece (Stete or Fore try) n Carolir
15. Decedent's Education 16. Kind of Business/Industry 16. Decedent's Usual Occupation 16. Decedent's Usual Occu	Mo sa	- 1		<u> </u>	10c. Cit	ty, Town or Lo	cation				10	Od. Inside City Lim
15. Deceder's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12. College (1-4or 5+) 12. Teither's Name (First, Middle, Last) Milton L. Megahan 19a. Informat's Name/First Indiations (Drype, Print) Patricia J. Crescenzi 20b. Pleas of Disposition AB guide 2 College (1-4or 5+) Patricia J. Crescenzi 20b. Pleas of Disposition AB guide 2 College (1-4or 5+) 21b. Melling Address (Street and Number or First Roads Number, City or Town, Sate, Zip Code) 22c. Mayno of Disposition AB guide 2 College (1-4or 5+) 23c. Pert I. Enter the disease, or complications the caused the death of College (Print) 23c. Pert I. Enter the disease, or complications the caused the death of College (Print) Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of): 24c. Wes en eutopsy performed? 24d. Were eutopsy evellable profor of death of the performed? 25d. Pleas of Death (Proch) and the cause of death of the performed? 26d. Pleas of Death (Proch) and the performed? 27d. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 26d. Pleas of Death (Proch) and the performed? 27d. Were eutopsy evel subble proformed? 27d. Were eutopsy evel subble proformed? 27d. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 27d. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 27d. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 27d. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 27d. Perc of Death (Proch) 27d. Were eutopsy evel all pert of death of the pert of death of the pert of death of the pert of death of the pert of death of the pert of death of the pe	a-fa-		Maryland Prince	George's	C	amp Sp:	rings					1 ☐ Yes XX
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110 1 1018)	}	D	ere	D	-2312	5	3	101	57
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Madhu Mohan, M.D. 6504 Kenilworth Avenue #200 Riverdale, Maryland												



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death MARCH 1, 1997 **Physician** EDWARD V INCENT CLAGGETT 10:37pm. /Medical 4a. Fecliity Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** COMMUNITY HOSPITAL LANHAM-SEABROOK PRINCE GEORGE'S CO If Undar 1 Yeer If Undar 24 Hrs. 8, Data of Birth
Months Days Hours Min. (Month, Day 5. Social Security Number 7. Aga (In yrs. last birthday) 59 Yrs. 9. Birthplece (Steta or Foreign **Funeral** 1 M 2 □ F Washington, D.C. 578-46-5373 Director May 6, Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Forestville Prince George's Mary land 1 XX es 2 □ No Director 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 20747 2523 Millvale Avenue Completed by Funeral 11. Marital Status 12. Wes Decedant Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Bleck, White, atc. filed within 72 hours after Nevar Merried 2 ☐ Married 1 Yes 2 No If Yes, Give Yaar or Dates: Baltimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuei Occupation (Give kind of work done during most of working iife. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondery (0-12) 12th grade College (1-4or 5+) Giant Food Store Baker permit. Pages 1 end 2 should be file Department of Health end Mentel Hy Important: If flem 27 is marked other any injury or other treumatic event, pages. 18. Mother's Neme (First, Middle, Meldan Sumama)
Mary Brawner 17. Fether's Neme (First, Middle, Last) Be Spencer Claggett 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 7108 Meadow Green Terrace Landover, Maryland 20785 Mr. Edward V. Claggett, Jr. (Son) 20b. Plece of Disposition (Neme of 20e. Mathod of Disposition Dete 20c. Location - City or Town, Stata Harmony Memorial Park 1 ☒ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stata 3/8/97 Landover, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 23a. Part 1. Enter the gleas por complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or hear in ure, u st only one cause on each line. Approximete Interval Between Onsøt end Deeth **Physician** /Medical Immediate Cause (Final diseesa or condition resulting in deeth) SDIVA Examiner Examiner The law requires that the death certificeta be executed Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Ceuse (Disease or Injury that initiated events the buriel-tren Due to (or es e consequence of) Box 68760. physician Completed by Physician/Medical thet initieted events resulting in deeth) Last Dua to (or es a consequenca of): 89 USe Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilebie prior to completion of cause of deeth? 24e. Wes an autopsy performed? 1 Yes 2 No this certificate 1 ☐ Yes 2 No or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Piece of Death (Check only one) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 ☐ Yes 2 X No Certification: To 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funerel 27. Menner of Deeth 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred After 1 Neturei 2 Accident 5 Pending after death. 1 ☐ Yas 2 ☐ No Investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 HomicIde To the Hospital of within 24 hours at to the Funeral D Scertifying Physician: To the best of my knowledge, deeth occurred et the time, date end piace, end due to the ceuse(s) end manner es steted.

| Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end piace, end due to the cause(s) end menner steted. 29e. Certifier Medical (Check only one) 29b. Signature and the of cartifler 29c. License number 29d. Date signed (Month, Dey, Year) ot person who completed cause of deeth (Item 23a) (Type, Print) Mitchellville 31. Dete filed (Month, Dey, Year) Registrer's Signeture State 07 Registrar

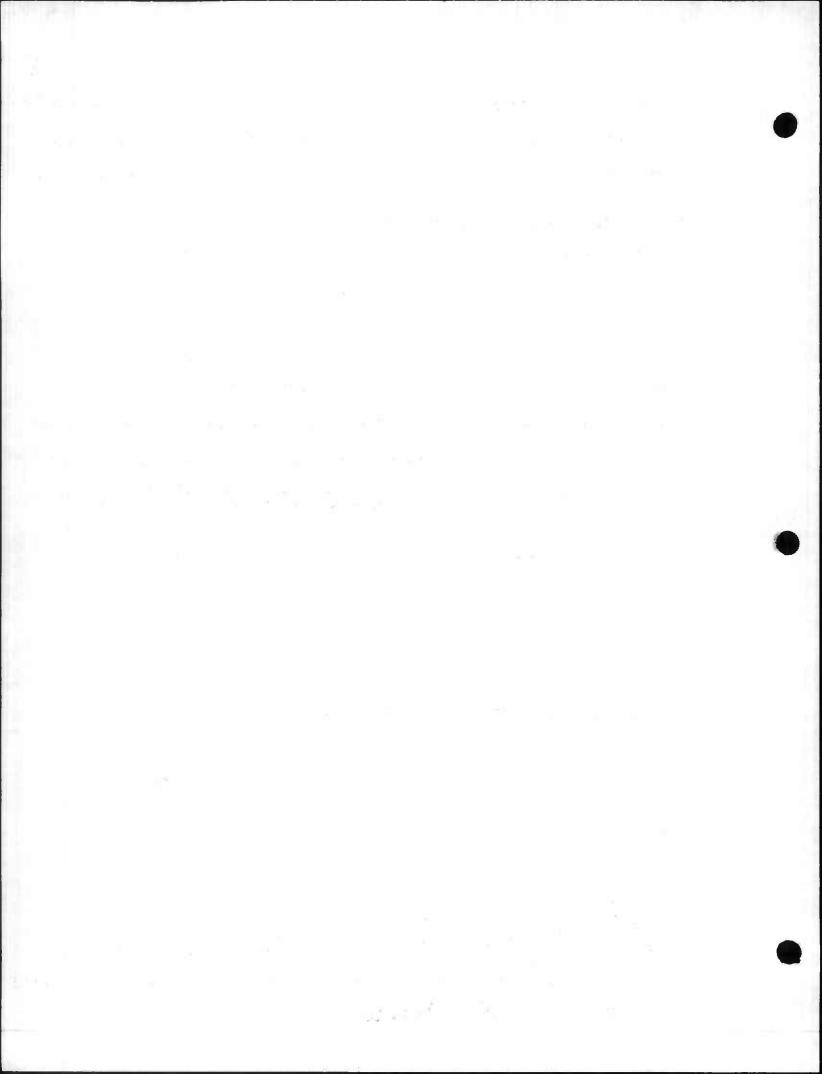
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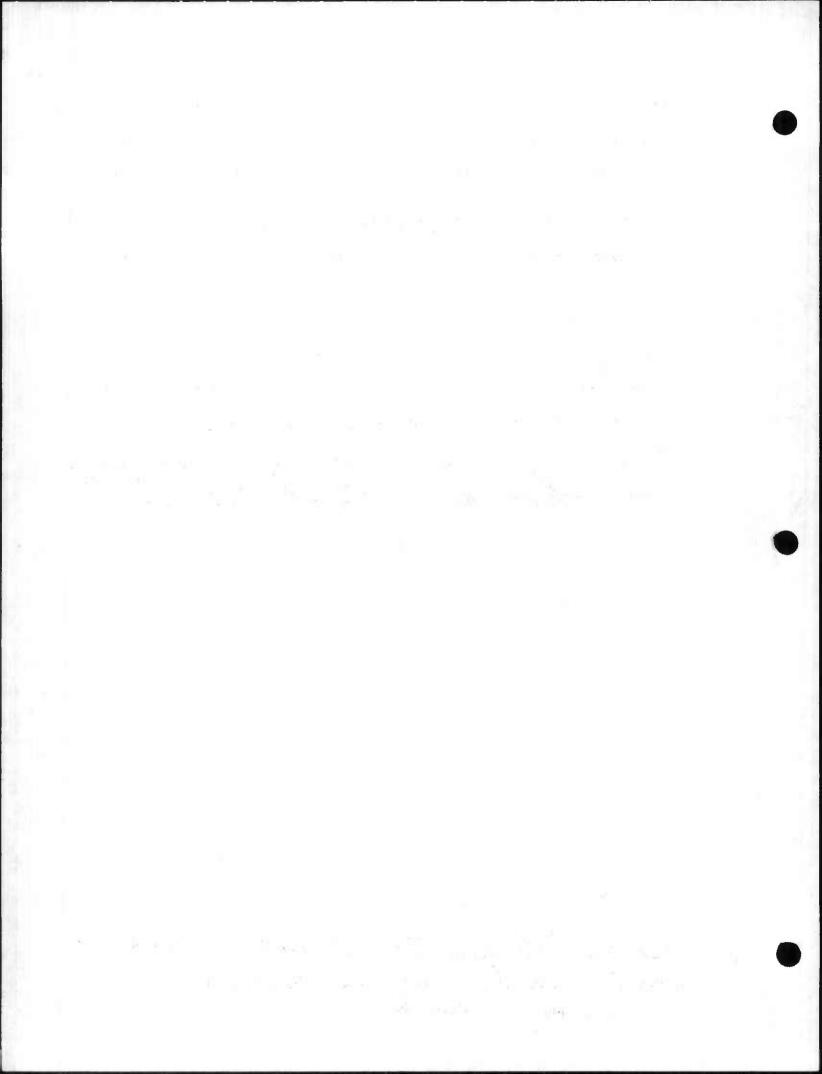
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Examiner		Town, or Location of Deeth 4c. Sounty of DERLY FRINCE	GEORGES
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19)	30. Name end address of person who completed cause of death (Ifg/h 23a) (Type, Print)	DRIVE , EHEVERLY, 1	
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State of Maryland / Department of Health and Mental Hygiene

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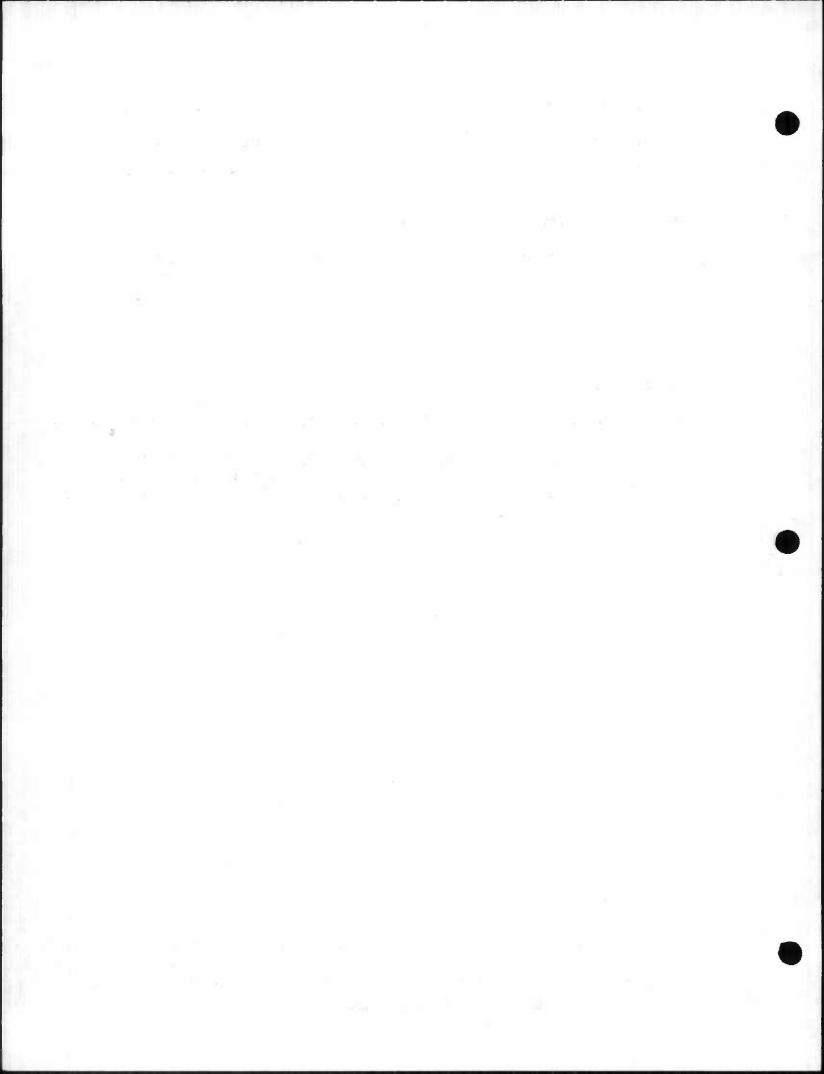


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	13		Decedent's Name (First, Middle, Last)			ocrimoate or	Doutil	2. Date of Dea	Reg. No.		. Time of Deeth
ı	Physici		ROBERTA SHAHIN DOUG	HERTY				Month FEBRUAL	RY 26, 1	Year 1997 7	A.M.
	/Medic Examin		4a. Facility Name (If not Institution, give stre	et and number)			4b. City, Town, or Lo				
			SHADY GROVE ADVEN	TIST HOS	PITAL		ROCKVILLI	Ξ	MONT	GOMERY	
П	Funeral		5. Social Security Number 8. Sex	7. Age	(In yrs. last birti	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h v. Year)1953		(State or Foreign
	Director		220-62-9050 1 M	X	44. Y	rs.		January	y 20	New ?	York
	pus Man		10a. State 10b. County	-	I Oc. City, Town	or Location				10d.	Inside City Limits
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	death with the Maryland ma 23a or 28a-f show r.must be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V		
	th will		969 Paulsboro Drive			20850)		U.S.A		
	ema er m	Funeral		Was Decedent Ev Armed Forces?	er In U,S.	13. Was Decedent of H If Yes, specify Cube		ecify Yes or No-	14. Rac	e - American II	ndian,
Maryland 21215-0020	n 72 hours after death with the Marylar "natural", or items 23s or 23s-f show edical Exeminer must be notified at	by	1 ☐ Never Married ※XX Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes ZQNo if Yes, Give Year or Dates:		1 ☐ Yes ZONo	Specify:	riioan, oto.,		White	
4	72 h	Completed	15. Decedent's Educati (Specify only highest grade of	on om <i>pleted)</i>	16a. l	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	ation during most of work	ina	16b. Kind of Bu	usiness/Industr	ry
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D 2	10 To Ac. 400		17. Father's Name (First, Middle, Last)	5+	I	mmuniologis	18. Mother's Name	/First Middle	Health	101	
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ar.	2 should be and Menta a marked aumatic sy	To	19e. Informent's Name/Relationship (Type,		19b.	Melling Address (Street				State. Zip Coc	de)
			James V. Dougherty/	Husband		9 Paulsboro					
ore	at - 40 0		20a. Method of Disposition		20b. Place of cometer)	Disposition (Neme of cramatory or other place	ce)	Date	20c. Location -	City or Town,	State
Ĕ	Pages ment of it writ: If the ury or o		1 N Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State		ia Gardens		3/2/97	Arlingt	on. Vi	rginia
Baltimore,	permit. Page: Department of Important: If I any injury or 2005.		21. Signature of Funeral Service Licenpee	low.		22. Name and Addre	ss of FacilityJose	ph Gawl	ler's So	ns,Inc	•
Ě	-		23a. Fartt. Enter the disease, or complicat	ons that caused th	ne death. Do n	ot enter the mode of dyir	ng, such as cardiac	or respiratory ar	rest,	Apr	proximate
	Physician		of the control of the	ause on each line	_					On	erval Between set and Death
	/Medical Examiner		Immediate Cause (Final disease or condition		SEPTIC	SHOCK	,			<	IDAY
В	LAGITIME	_	resulting In deeth) a.	Di	ue to (or as e c						- 1
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	\$ D 8		resulting in death) Last							i	
Box	attending for use a	an	d								
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۵.	that the sed by detac							10	Yes 2□ No	3 Probabl	y 45 Unknown
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ta	certificate		25. Was case referred to medical				26. Plece of Deat) (Check colu		1 ☐ Ye	es 2/2 No
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Sio	endin eath. or: Af the fu	atic	2 Accident investigation	1	,		Yes 2□No				
Division	or Attendation of Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	8e. Place of Injury building, etc.		m, street, factory, office		28f. Location (S City or Tox	Street and Numb vn, Stete)	er or Rural Ro	ute Number,
	pital ours a oral	-	20e Certifier ME Coult the Disselate	- T- the bt-f		4			42		
	To the Hospital or Attending Phymitin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	29a. Certifier (Check only one) Certifying Physicial Examinar:	On the basis of e and manner state	xaminetion and	death occurred et the tir for Investigation, in my o	ne, date and place, pinlon, deeth occurr	ed et the time,	dete and place,	nner as steted and due to the	cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	/		29c. Licens	e number		29d. Date signed	d (Month, Day,	Year)
			Mandrell &	Japen	71078 9.	actici and	D 3011.	2	FEBRUX	ARY 2	7,1997
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State of Maryland / Department of Health and Mental Hygiene

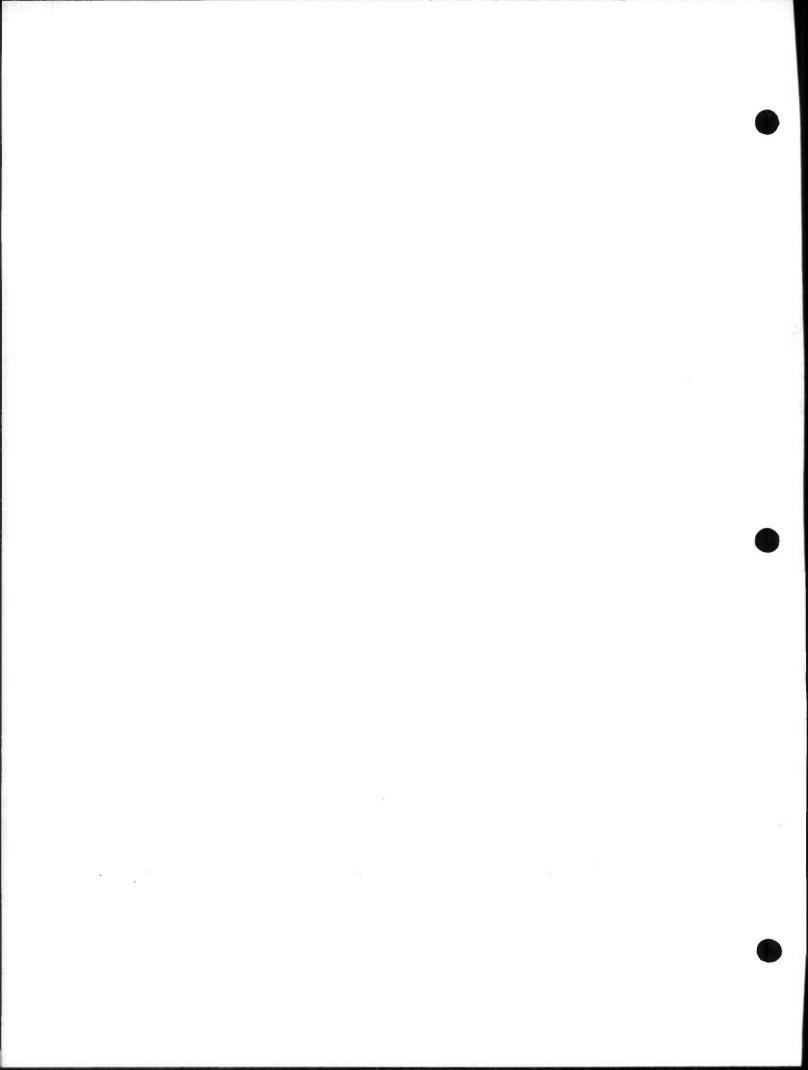
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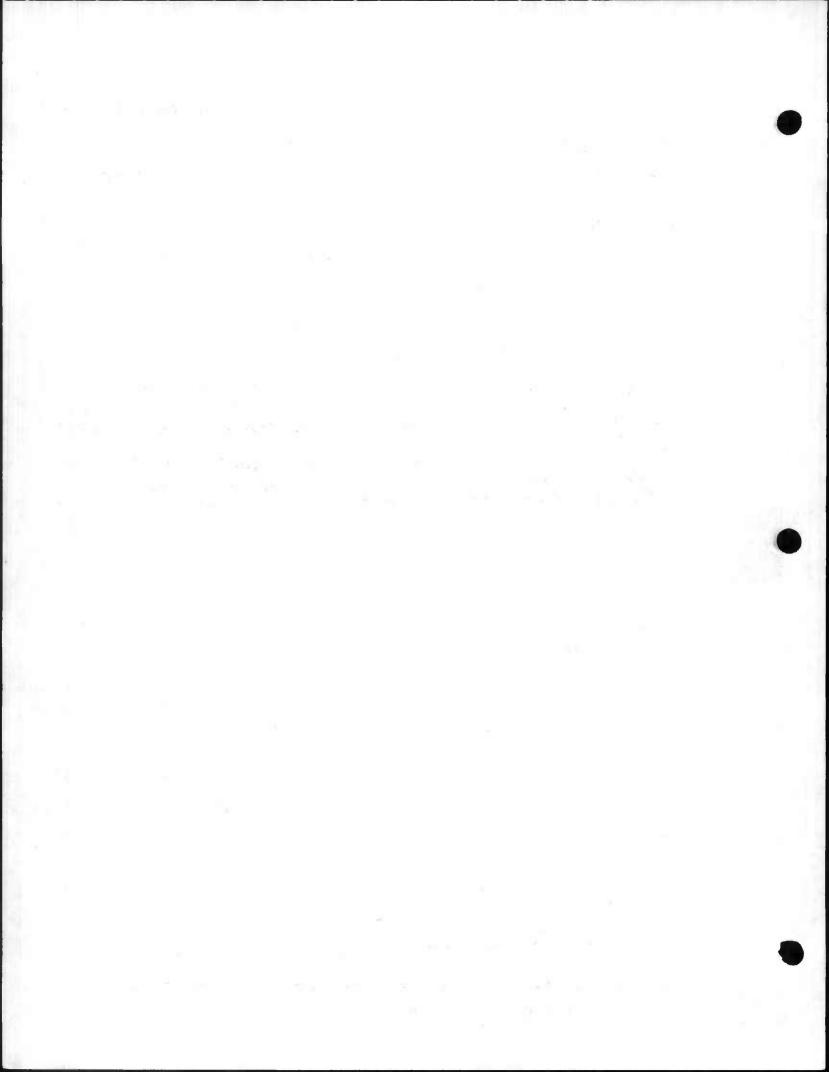
					State o	f Maryla		irtment of F tificate of	lealth and N <i>Death</i>	Mental Hy	giene Reg. No.	97 0	18226
			1. Decedent'a Name (F	First, Middle, i	Last)					2. Date of De	ath	3.	. Tima of Death
	Physici /Medic		LUCILI	LE V	7. DAV	IS				Month March	2, 1	997	1810
3	Examir		4a. Facility Name (If no						4b. City, Town, or L				
					DVENTIST			If Undar 1 Year	ROCKVILI If Under 24 Hrs.			GOMERY	
	Funeral Director		5. Social Sacurity Num 579-12-2 Usual Rasidance of De	182	Sax 1□M XONE	7. Age (In y/s	(lest birthday) Yrs.	Months Days	Hours Min.	8. Data of Bir (Month, De Sept.	2, 191	_ Country)	(Steta or Foreign
	fend fand			0b. County		10c. C	ity, Town or Loc	cation				10d. I	Inside City Limits
	Marylo a-f show iffed at	tor	MD	Monto	gomery	1	Rockvi	lle				1	1 □XYes 2 □ No
	h with the 13e or 28 at he not	Funeral Director	10e. Street and Number 222 Fre		ck Aven	ue		10f. Zip Code 2085	0		10g. Citizen of V	•	
020	urs after death with the Maryla at, or Nens 23a or 23a-f shor Examiner must be notified at	þ	11. Marital Status 1 ☐ Nevar Married 3 🖾 Widowed 4 ☐		12. Was Deca Armed Fo 1 Yes If Yes, Giv Year or Da	rces? 2 X No e	If	Vas Decedent of H Yes, specify Cuba	lispanic Orlgin? (Sp an, Maxican, Puerto Specify:	pecify Yes or No Rican, etc.)		a - American Ir ck, White, atc.	
21215-0020	within 72 ho ins. then "neturn to Medical.	Completed	(Specify Elementary/Seconds		Education trade complated) College (1	-4or 5+)	(Give I life. D	ent'a Usuai Occup kind of work done OO NOT use retired USEWife	during most of work d)	ring	16b. Kind of Bu		У
	Hygie Ather ant, 11		17. Fathar's Name (Fire	st, Middle, La	st)		ПО	usewile	18. Mother's Nam	e (First, Middle			
Maryland	dental dental rhad o	To Be	Frederic	ck Hov	vard				Mary	Wood			
ary	and No.		19a. Informant'a Name	e/Reiationship	(Type, Print)		19b. Mailin	g Address (Street	end Number or Rui	ral Route Numb	er, City or Town,	Stete, Zip Coc	¹⁰ 20706
9723	and ealth n 27 her tr		Rev. Rodr		avis (S	on)			nd Ave.				
Baltimore ,	Pages 1 nent of H int: If the ury or off		20a. Method of Disposi 1 Burial 2 0 4 0 Donation 5 [remation 3		State		sition (Neme of netory or other place Park Ce	metery	3/8/97	20c. Location -		
Balt	permit. Page Department of Important: If any Injury on since.		21 Signature of Funan	al Service Llo	anoge 1		/ S	Name and Addra NOWDEN OCKVILI	FUNERAL	HOME,	P.A.		
	Physician (Marking)		23a. Part1. Enter the c shock, or heart fa		mplications that cally one cause on e	aused tha dea		r tha moda of dyir	ng, such as cardiac	or respiratory a	rrest,	Inte	proximate erval Between set and Death
	/Medical Examiner) e	Immediate Causa (Findisease or condition rasulting in daath)	aı	a. 70	Due to	onuni	Ful-	rosis ardin			4	yrs
	cuted nd ransit	Examiner	Sequentially list condit	tions.	ь. — О	Due to	or as a consequ	sence of	ardin	<u> </u>		4	leavs
68760,	icate be executed physician and the burial-transit	dical Ex	Sequentially list condit if any, leading to Imme cause. Entar Underlyin Cause (Disease or inju- that Initiated events		c. R	espe	ratur	Y Y	rest			2	dayso
Box 68	death certifical e ettending phy od for use es th	w	resulting In death) Last		d	7		7		_			•
	0 0 0	sicia	Part II. Other significar	nt conditions	contributing to de	ath but not re	suiting in the un	derlying cause giv	ren in Part I.	23b. Dld	tobacco usa co	ntributs to the	cause of death?
s, P.O	that the ed by detac	by Physician/M	Conge	/ -	Hear	1	6			10	Yes 2□ No	3 Probably	y 42 Unknown
Records	2 S S	Completed b	/		Eggregation (an autopsy ormed?	availab	autopsy findings sle prior to stion of cause th?
E.	The ate h	Con								10	Yas 2000	1 □ Ya	s 2 No
Vitai	ysician: The s certificate director, pag	Be	25. Was case referred examiner?		Managaria			0"	26. Place of Dea	th (Check only	one)		
of	this el di	. To	1 ☐ Yes 2 ☑ No 27. Mannar of Death		Hospitai:		28b. Time of		4 C Hadishild Life		denca 6 Oth		
P	ding F th. After Juner	tlon		Pending investigati	(Mont	h, Dey Year)	Injury	28c. Injur Wor M 1 🗆	k? Yes 2 □ No	20d. Describe	now injury occur	60	
Division	or Attending effer death. Director: After 3 in by the lune	Certification:		Could not datarmine	be 28e. Piaca	of Injury · At h	noma, farm, stre	et, factory, office		28f. Location (City or To	Street end Numb wn, Stete)	er or Rural Ro	ute Number,
	To the Hospital within 24 hours e To the Funeral Completely filled	edical C	29a. Cartifiar 15 (Check only 25 one)	Certifying F	Phyaician: To the aminar: On the ba	isls of axamin	owiedge, daath ation and/or inv	occurred at the tir estigation, in my o	ne, date and place, pinion, daath occur	and due to the red at the time,	cause(s) and ma date and placa,	inner as stated and dua to tha	i. cause(s)
	within Fo the comple	Me	29b. Signature and title	of certifier		n		29c. Licens	e number	T	29d. Date signe	d (Month, Dey,	, Year)
			Allon	11	/	W M	5	29	300		March	3/	4904
		ŀ	30. Nama and addresa	of person wh	o compiatad caus	e of death (Ite							
	1/		Robert L.		d, M.D.	1522			Rd., R	ockvi	lle, MD	20850	0
	Sta Registr	-	31. Data filed (Month, L	MAR 0	5 1997 Þ	egistrade Sign	Davidson-	Mandall.					

S BALTIMORE, MARYLAND 21215-0020	24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to buriat, cremation, or removal.	he medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Memal Hyglene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI	MENT OF H	EALTH AND N	MENTAL HYGIEN	E	1 00221
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	JORDAN L. DOMBROWS	SKI				02-27-19		7:20 PM M
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE		F UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BIRTH		B. BIRTHPLACE (State or Foreign
	352-22-6995	æ m ² □ f 65	YRS.	ONTHS DAYS	HOURS MIN.	(Month, Day, Year) 06-15-19	31 1	Country) ILLINOIS
	9e. FACILITY NAME (If not institution, give street	and number)	9	b. CITY, TOWN	OR LOCATION OF DE			Y OF DEATH
DIRECTOR	3402 FREDALE STREET	Г		WHE	ATON		MONT	IGOMERY
ñ	10s. STATE 10b. COUNTY		10c. CITY, 1	OWN OR LOCAT	TON			10d. INSIDE CITY
ă	MD MONTGON	MERY	WHEA	MOT				LIMITS? 1 YES 2 NO
A	10e. STREET AND NUMBER			101	. ZIP CODE		10g. CITIZE	EN OF WHAT COUNTRY?
FUNERAL	3402 FREDALE STREET	Г		2	0902		USA	
5	and the second s	. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IC ORIGIN? (Specify Yes		4. RACE — American Indian,
BY	1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR D	ATES		ecity Cuban, Maxicar 2 XNO Specify	n, Puerto Rican, etc.)		Black, Whita, atc.
_	5-17		NAVY	1			- 1	WHITE
COMPLETED	15. DECEDENT'S EDUCATH (Specify only highest grade com	ON pleted)	16a. DECEDENT'S US	k done during mo	ON st of working	16b. KIND OF BU	SINESS/INDU	STRY
ا ۳	Elementary/Secondary (0-12)	ollege (1-4 or 5+)	IHe. Do NOT use r		OT A TONIG	DOT TITE	a /n===	
M M		2	WRITER/PU	BLIC K				L ESTATE
8	17. FATHER'S NAME (First, Middle, Last)				A	ME (First, Middle, Meiden	Sumame)	
出	NATHAN DOMBROWSKI					ECHINSKY		
6	19a. INFORMANT'S NAME (Type/Print)	A LTC/LIMETO	and the second second second			loute Number, City or Tow		
	KATHY DOMBROWSKI/DA					THERSBURG		20877
ı	20a. METHDO OF DISPOSITION 1 Description 1 Removat	trom State 20t	D. PLACE AND DATE OF I	DISPOSITION (NE	me of	OATE 20c. LO	CATION — CI	ty or Town, Steta
- 1	4 Donation 5 Other (Specify)	CI	HELTENHAM			3/4 UPPE	R MARI	BORO, MD
	21. SIGNATURE OF POWERAL SERVICE LICENS	//			O ADDRESS OF FAC	TUNERAL DI	DECTI	M
	EMAN					E PIKE, RO		
	23. PART I. Enter the diseases, or com	plications that cause	d the death. Do not	enter the mo	de of dying, such	aa cardiac or reap	ratory arres	nt, Approximata
	shock, or heart failure. List IMMEDIATE CAUSE (Final	only one cause on e	ach line.					Onset and Death
	disease or condition resulting in death)	RENAL	1 INSUR	FILLE	NOT			
		DUE TO (OR AS	A CONSEQUENCE OF):					
z	Sequentially list conditions, b		OTIC.	SYND.	rone			
CERTIFICATION	if any, leading to immediate		CONSEQUENCE OF):		,			
2	cause. Enter UNDERLYING CAUSE (Disease or Injury	DIABET	ES ME	WIT	V5			
<u> </u>	that initiated eventa resulting in death) LAST							
50	d	HYPER	TENSIO	~				
AL	PART II. Other significant conditions co				g cause given in i			24b. WERE AUTOPSY FINDINGS
ই	CONGESTIVE	HESRT	Forle	INE		PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDIC	- 8-				/	1 YES 2		OF DEATH?
2	DID TOBACCO USE CONTRIB	UTE TO CAUSE C	DE DEATH YES	I NO E	UNCERTAIN			1 YES 2 NO
₹	25. WAS CASE REFERRED TO MEDICAL	01210 01002 0	26. PLACE OF DEATH		OTTOLKIAII			
PHYSICIAN:		OSPITAL: Inpetient 2 ER/Out	petient 3 DOA 4	THER:	e 5 Haeldenca	8 Other (Specify)		
Ě	27. MANNER OF DEATH	26s. DATE OF INJURY	26b. TIME C	F 28c. INJ	URY AT	26d. DESCRIBE HOW I	NJURY OCCU	RED
ВУР	1 Natural 5 Pending	(Month, Day, Year)	INJUR	M 1 🗆	RK7 FES 2 NO			
	2 Accident Investigation 3 Suicide 6 Could not be	26a. PLACE OF INJURY	/ — At home, term, atra	et, factory, offic		26f. LOCATION (Street		Rural Route Number,
입	4 Homicide determined	building, etc. (Spe	cny)			City or Town, State)		
COMPLET	29a. CERTIFIER	: To the best of my know	dados daeth occurred	of the time, date	and alone and duri	- N		
₹ I								cause(s) and manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIER			miny opinion, c				
H	THE SHARK OF AND THE OF CENTIFIER	1.11		40	29c. LICENSE NUM			SIGNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO CO	MOI ETED CAUSE OF	ATU JITEM OT JE		044	025	rec	L 28, 1997
	May LINDA MABE				Ila D.L.	Rockville	607	70562
	31. DATE FILED (Month, Day, Year)	32. REGISTBAR'S SIGN		1 LOCUPI	he //ve	TOCKUITE		~-036
	MAR 0 3 1997		widson-Randa	00				
1	111111 0 0 1331	10000	macan-hadar	بالل				



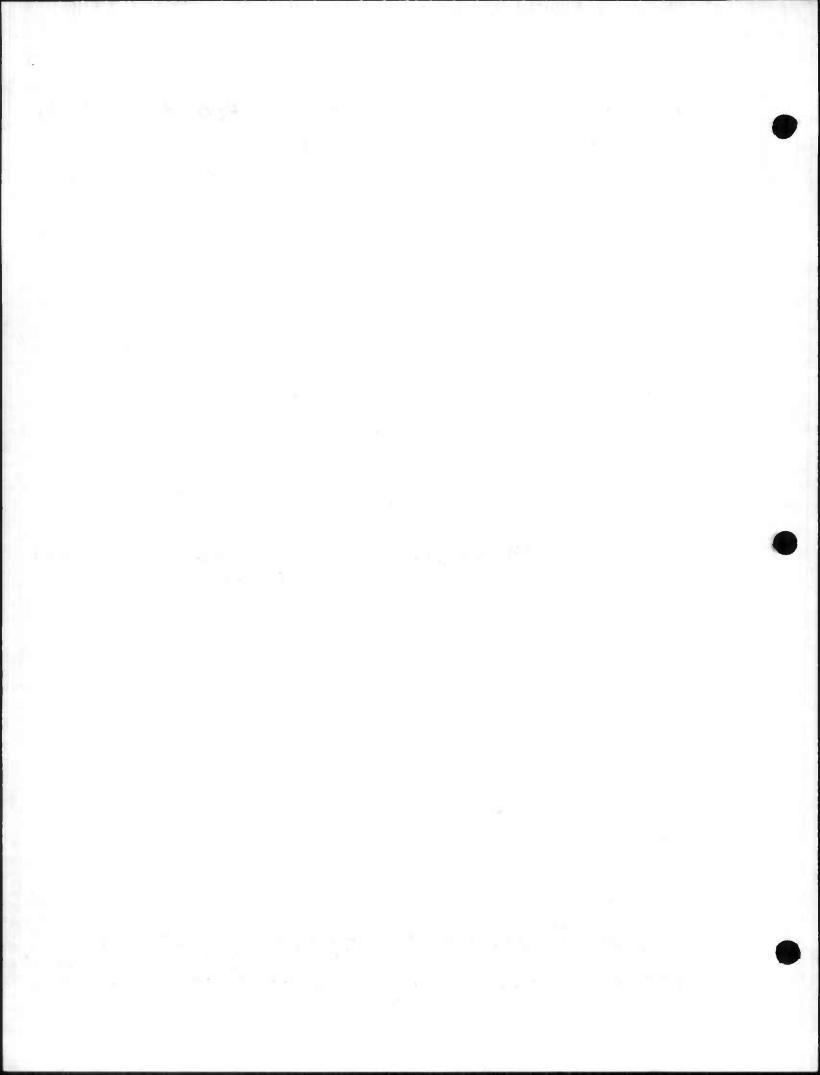
	1. Decedent	's Name (First, Mic	ddle Lest	1		Cer	tificate	of L	Jeath	2. Dete of	Reg. No	o.	97	0 8 2 2
ian	Jose			ndero						Month	Da		Year	
cal ner		Vame (If not institut			ber)			4	b. City, Town, or	Febru Location of De	-	County o		7:30 A
	3607	Gleneag	les l	Drive				S	ilver S	oring		Moi	ntgom	erv
Г		curity Number	6. Se:	x	. Age (In yrs	. lest birthday)	if Under 1 Months	Year	If Under 24 Hrs Hours Min	s. 8. Date of	Birth Day Year	, ,		ice (Stete or Forey)
		38-5352	10	M 2□F	85	Yrs.	THO INTO	Duyo	110013	June				ngton,D
	10a, State	ence of Decedent 10b. Cour	nty		10c, C	ity, Town or Loc	ation							d. Inside City Lin
ō	Manari a	W												1 ☐ Yes 2 ☐
Director	Maryla 10e. Street 8		tgome	ery		Silve	10f. Zip C	ing			10g, Ci	tizen of W	hat Countr	
O	3607	Gleneag	100 1	Drivo				209	0.6					
Funeral	11. Maritel S			12. Was Deced	ient Ever in I	J,S. 13. V	Vas Deceder	nt of Hi	spanic Origin? (Specify Yes or			- America	
Fu		er Married 2 M		1 Yes	2⊠ No		Yes, specing		Specify:	to Hican, etc.)			, White, et	.c.
d by	3 5 Wide	owed 4 Divorc	ad	Yeer or Da				2110	орвону.			Specify:	Wh	Lte
Completed		15. Deced (Specify only high	ent's Edu hest grad	cation e <i>completed)</i>		16a. Deced	ent's Usual kind of work	done d	ition uning most of wo	rking	16b. F	(Ind of Bus	siness/Indu	stry
дшо	Elementar	y/Secondary (0-12	2)	College (1-				retirea,						
	17. Father's	Name (First, Middl	le, Last)	5+		Attor	ney		18. Mother's Na	me (First, Mid	Law dle, Maidei)	
To Be	Rapha	el L.	Do	ndero					Dos	11100	р	T - h -		
-	-	ent's Neme/Relatio		The second second		19b. Mailin	g Address (S	Street a	nd Number or R	lural Route Nui	nber, City	Lehr	Stete, Zip C	Code)
	John	Dondero				8720 6	leorgi	а А	venue #	704 511	war S	brin	~ Mar	20910
		of Disposition	- 200	lamaval from C		Place of Dispos cemetery, crem	ition (Name atory or oth	of er place	venue #	Date	20c. L	ocation - C	City or Tow	n, State
		ation 5 Other		emoval from 5		t Linco	ln Ce	met	erv	3/03/9	7Brer	twoo	d Mar	vland
	21. Signatur	uneral Service	be License			22.	Name and	Addres						y Land
	K	obutt	E.A	amse	7									MD 2090
er	Immediate C disease or c resulting in c	ondition	8	. Acute		rdial I		tio	n				10	Mins.
Examiner	Sequentially if any, leading	list conditions, ng to Immediate or Underlying ase or injury	f "). ————	Due to (or as a consequ	ence of):							
edical E	Cause (Dise that Initiated	r Underlying ase or injury events	< .		D 1- /	or es e consequ							i	
큣	resulting in o	leath) Last			D00 (0 (1	or es e corrisedo	onca ory.							
				l										
	Part II. Other	aignificant condi	tions con	tributing to dea	ìh but not rea	sulting in the un	derlying cau	ise give	n in Pert I.	23b. D	id tobacco	use cont	ributs to t	he cause of dea
Physician/M	Part II. Other	algnificant condi	tions con	I. tributing to dea	th but not rea	sulting in the un	derlying cau	ise give	n in Pert I.			1		he cause of dea
by Physician/M	Part II. Other	algnificant condi	Itions con	I. tributing to dea	th but not rea	sulting in the un	derlying cau	ise give	n in Pert I.	1 24a. W		×No :	3 Proba	
by Physician/M	Part II. Other	algnificant condi	itions con	tributing to dea	th but not rea	sulting in the un	derlying cau	ise give	n in Pert I.	24a. W	as en euto	×No :	3 Proba	e eutopsy finding eble prior to pletion of cause eath?
Physician/M		e referred to media	cal		th but not rea	sulting in the un	derlying cau		26. Place of De	24a. W	as en eutorformed?	psy	24b. Wern eveil comported to de	e eutopsy finding eble prior to pletion of cause eath?
To Be Completed by Physician/M	25. Wes cas exeminer	e referred to medic ? 2	cal	ospital: 1 ☐ In	patient 2] ER/Outpatient	3□ DOA	Othe	26. Place of De r: 4	24a. W pe 11 lineth (Check on thome 5 K Re	as en eutorformed? Yes 2 Yes 2 y one) esidence	psy No Other	24b. Werrevell comported to the comporte	e eutopsy finding eble prior to pletion of cause eath?
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State of Maryland / Department of Health and Mental Hygiene

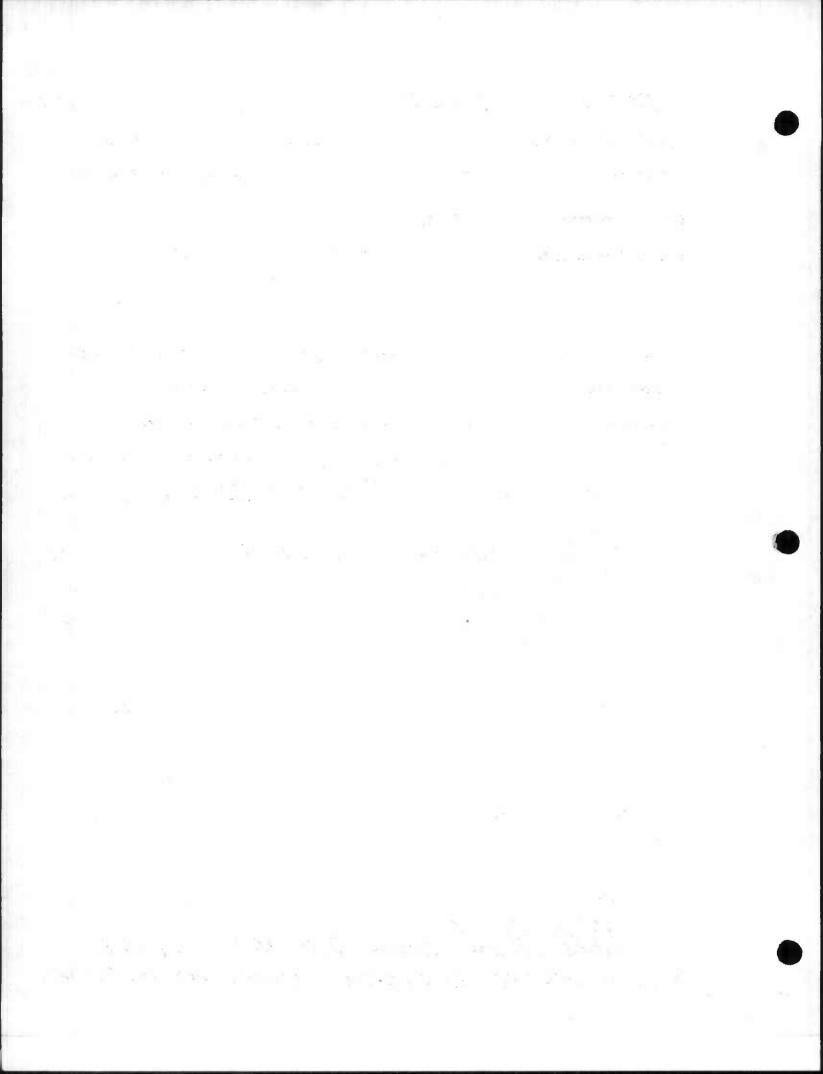
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	Ce	ertificate of Death	Reg. No.	00223		
Physician	1. Decedent's Neme (First, Middle, Last)	Donahue Ja	P. Dete of Deeth Month Day Yeer PFB A0 1997	3. Time of Deeth		
/Medical Examiner	4e. Fecility Neme (If not institution, give street end number)	4b. City, Town, or Loca		, o pinj		
	Suburban Hospital	Bethesda	Montgomer	CV		
Funeral	5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthda)	Months Deys Hours Min.	B. Date of Birth (Month, Dey, Year) 9. Birth Cou	plece (Stete or Foreign intry)		
ector	218-56-3176 44 YIS. Usuel Residence of Decedent	M	arch 6, 1952 Wash	ington, D.C		
	10a. Stete 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits		
ctor	Maryland Montgomery Bethese	da		1 ☐ Yes 2 ☒ No		
Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	intry?		
	5322 Glenwood Road	20814	U.S.A.			
Funeral		. Was Decedent of Hispenic Origin? (Speci If Yes, specify Cuben, Mexican, Puerto Ri	ify Yes or No- can, etc.) 14. Rece - Ameri Bieck, White			
by F	1 Never Merried 2 Married 1	1 ☐ Yes 2 ☒ No Specify:	Specify:			
	15. Decedent's Education 16e. Dec	edent's Usuel Occupation	16b Kind of Business/Ir	White dustry		
Completed	(Specify only highest grade completed) (Giv Elementery/Secondery (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)				
5	4 Manufa	acturer's Representa		ipment		
e e	17. Fether's Neme (First, Middle, Last)	18. Mother's Neme (i	First, Middle, Maiden Sumeme)			
L O	Robert C. Donahue, Sr.	Zoe M. J				
	19e. Informent's Neme/Reletionship (Type, Print) 19b. Mei 3511	ing Address (Street end Number or Rurel F Davenport Street, N	Route Number, City or Town, Stete, Zij N.W. Apt. 409	p Code)		
	Jill A. Donahue Was 20e. Method of Disposition 20b. Plece of Disp	Davenport Street. Name of D.C. 2000	Dete 20c. Location - City or T	own. Stete		
	1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State	emetory or other place)				
**	Official Co	emetery 3/ 22. Name end Address of Fecility	03/97 Leesburg, Vi	irginia		
ON COLOR		rancis I Colling Fr	meral Home, Inc.			
	23a. Pert1. Enter the disease, or complications that gaused the deeth. Do not en shock, or heert failure. List only one ceuse on each line.	500 University Blvd. nter the mode of dying, such es cardiec or r	,W.,Silver Spring	Approximate		
ian	snock, or neert tallure. List only one ceuse on each line.			Onset end Deeth		
ical	Immediate Cause (Fine) disease or condition resulting to death) 8. METASTATIC	DECTA CAN	CFR 70 6	WEEK (
ner	resulting In deeth) Due to (or es e conse		50			
Examiner	b					
al Examir	Sequentielly list conditions, if ery, leeding to immediate cause. Enter Underlying	equence of):				
Ca	thet initiated events					
Medi	resulting in deeth) Lest	querios ory.				
lan	d					
y Physician	Pert II. Other significant conditions contributing to death but not resulting in the	underlying cause given In Part i.	23b. Did tobacco usa contributa t			
			1 Yes 2 No 3 Pro	bably 4 Unknown		
leted by			24a. Wes en eutopsy 24b. W	/ere eutopsy findings veilable prior to		
plete			CC	veilable prior to empletion of cause deeth?		
Completed			_ \	☐ Yes 2☐ No		
(0)	25. Wes case referred to medical	26. Plece of Deeth (D 165 2 D 160		
ToB	exeminer? 1 Yes 2 No Hospitel: 1 Impatient 2 ER/Outpetie	Other	5 ☐ Residence 6 ☐ Other (Speci	ify)		
	27. Manner of Deeth 1 Neturei 5 □ Pending 28e. Dete of Injury (Month, Dey Year) 1 Injury	of 28c. Injury et 28 Work?	d. Describe how injury occurred			
Certification:	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No				
rtiff	4 Homicide determined 28e. Piece of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	 Location (Street end Number or Rur City or Town, Stete) 	al Route Number,		
2	29e. Certifier 12 Certifying Physician: To the best of my knowledge dee	***	44.4.4			
Medical Certifi	29e. Certifier (Check only one) 1. Certifying Phyelclan: To the best of my knowledge, dee 2 Medical Examiner: On the best of examination end/or is end menner steted.	in occurred at the time, date and piece, and nvestigation, in my opinion, death occurred	et the time, date end plece, end due t	to the ceuse(s)		
Me	29b. Signature end title of cartifie	29c. License number	29d. Dete signed (Month,	Dey, Year)		
	Karofo Brodunks Kill	737236	2/26/97	7		
	30. Name end eddress of person who completed cause of deeth (Item 23a) (Type	Print)	#300 1	Zockriut		
9	CAROLYN B. HENDRICKS M.) 9707 MEDICA	# 300 / # CENTER Deive	mp		
State	31. Dete filed (Month, Dey, Year) MAD 0 2 1007 32. Registrar's Signature					
egistrar	MAR 0 3 1997					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

ı						nai yiai ic		tificate of	Health and Death		Reg. No.	97	08230	
	Physici /Medi		1. Decedent's Nem	na (First, Middle, I	Last) L	ORS	SEY	/		2. Data of De Month MARCH	Dey	997	3. Tima of Death 6:20 AM	
	Examir	- 48	to Facility blanching the sale of the sale									of Death		
и.			Laurel R					W Hodes & Ves	Laurel				3. Time of Death 7 6:20 A M th eorge thiplace (State or Foreign ountry) 10d. Inside City Limits 1 N Yes 2 No ountry? arican Indian, ta, etc. te Undustry Complex Zip Code) 0707 Town, State aryland 707-4389 Approximate interval Batween conset and Death I DAY YCS YCS Tobelty 4 Unknown Ware autopsy findings aveileble prior to completion of cause of death? 1 Yes 2 No	
١	Funeral Director		5. Social Security N 214-26-3 Usual Rasidance o	163	Sax 1□M 2⊠F	Age (In yrs. ia 68	Yrs.	Months Dey				9. Birthp Cour Mary	placa (Stata or Foreign http:) "Land	
	E		10a. Stete	10b. County		10c. City,	Town or Loc	ation				1	IOd. Inside City Limits	
with the Marylans s or 28a-f show be notified at	to	MD	Howard		Sava	age						1 X Yas 2 □ No		
	th the M or 28a-t	Director	10e. Straat and Nu	mbar				10f. Zip Coda			10g. Citizan of	What Cour	ntry?	
	23a MIST b		9127-B B	altimore	Street			20763			USA			
Maryland 21215-0020	72 hours after death v natural", or lterns 23a dical Examiner must.	by Funeral	11. Marital Status 1 □ Naver Merr 3 □ Widowad	ried 2□ Married	12. Was Decedar Armed Forcas 1 Yas 2 If Yas, Giva Yeer or Datas	? (No	if	as Decedant of Yas, specify Cu □ Yas 2X No	Hispenic Origin? (ben, Maxicen, Pua Specify:	Specify Yes or No rto Rican, atc.)		ce - Amaric ck, Whita, White	atc.	
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and	8405		17. Fathar's Name	· Sillings	st)					ema (First, Middle,		na)		
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Baltimore,	permit. Pa Departmen important: any injury 2005		21. Signatura of Fu		**	147			•			, mar	yadra	
B	Dep Imp		21. Signatura of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389										07-4389	
			23a. Part1. Entar to shock, or haa	ne disease or col	mplications thet cause y one causa on each	ed tha daeth. line.	Do not ante	r the moda of dy	ring, such es cardia	ac or raspiratory a	rrest,		Approximate interval Batween	
	Physician / /Medical		Immediata Cause	(Final	M	Vaca	PDIA	1 /0/5	-000 ±1	- /		- 1	/ Day	
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90,	cian e		Sequentially list co if any, leeding to in causa. Entar Unda Causa (Disaasa or	nmediata arlying Injury	DI	ABET	SETES						YRS	
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P.0	het the de od by the detached	Physician/M	ran II. Other eignii	icant conditions	contributing to death	but not rasuit	ing in tha un	dariying ceuse g	Ivan in Part I.		lobacco uae co Yee 2□ No			
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C 5 5 5	Certification:	27. Mannar of Death 1 Natural 2 □ Accident 3 □ Suicida	2 ☐ Accident invastigation			8b. Tima of injury	M 1 E	ury at ork?]Yas 2□No	28d. Dascribe I	now injury occur	red			
Division of a star death. I Director: After a funar death.		Certifi	4 ☐ Homicide	determined	286. Pieca of in	ijury - At hom tc. (Specify)	a, farm, stre	at, factory, office		28f. Location (S City or Tox	28f. Location (Straat end Number or Rurel Routa Number, City or Town, Stete)			
	To the Hospital or Attendir within 24 hours after deeth. To the Funeral Director: Al completaly filled in by the fu	edical	29a. Certifier (Check only one)	1 Certifying P 2 Medicai Exa	hysician: To the bast miner: On the besis of and manner s	of axaminatio	adga, daath o n end/or Inva	occurred at tha t stigation, in my	ima, date and plac opinion, death occ	e, and dua to the urred at tha tima,	cause(s) and maddata and piece,	annar as st and dua to	ated. tha causa(s)	
	Tot	×	29b. Signature and	////	alles	AT	TENDIN		2409_		29d. Data signe	97	Day, Year)	
	10		30. Neme end addre	ass of person who	completed cause of RSTMO	deeth (Itam 2	(3a) (Type, P	T. AVE	T. COU	EGE 01	RK, M	0. 2	0740	
	Sta Registra		31. Data filed (Mont	th, Day, Year)	Hegist	rar's Signetu	a dall							



State of Maryland / Department of Health and Mental Hygiene 08231 Amended #1, 3/7/97, M.W.O., Howard Co. Certificate of Death 1. Decedent's Neme (First, Middle, Last) Dortha 2. Dete of Deeth **Physician** February 25, 1997 Dorotha Arlouine Davis 7:30 pm /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Pineview Nursing Home Clinton Prince George If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number 8. Dete of Birth 9. Birthplace (State or For Month, Day Year) OR North Dakota 7. Age (In yrs. lest birthdey) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Deys Hours 90 313-01-0244 Vrs Director Usuei Residence of Decedent 10a. Stele 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryta notified ah 1 Yes 2 No Director MD Prince George Clinton 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 7 is marked other than "natural", or items 23s or traumstic event, the Medical Examinar must be r 9106 Pineview Lane 20735 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14. Race - American Indien, Biack. White, etc. pamili. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or its any injury or other traumetto event, the Medical Examina 1 Never Merried 2 Merried 3altimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 ♥ No Specify If Yes, Give Yeer or Detes: þ 3 ₩ Widowed 4 Divorcad Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12)
Grade 12 Coilege (1-4or 5+) Grade Teacher education 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) John M. Gelfius 2 Margaret Linson 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Elizabeth Cherry daughter 4 Dover Drive, Cranberry Township, Pennsylvania 20b. Pieca of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Buriei 2 ☐ Cremetion 3 🖾 Removei from Stele 4 ☐ Donetion 5 ☐ Other (Specify) Garland Brook Cemetery 3/4/97 Columbus, Indiana 21. Signature of Furneral Service Licenses 22. Neme end Address of Facility any le Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physiclan** /Medical Immediate Cause (Final disease or condition resulting in death) YEARS · ARTERIOSCIERATIC CARPIOUASCULAR Examiner Due to (or es a consequence of) Examiner that the death certificate be executed physician and the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of). P.O. Box 68760 Physician/Medical Due to (or es e consequence of): 88 980 Po Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. the 23b. Did tobacco use contribute to the cause of death? yd bengis 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 8 24b. Were autopsy findings aveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed peeu certificata has 1 Yes 2 No 1 Yes 2 No Attending Physician: funeral director, 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Deet 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury al Work? 28d. Describe how injury occurred Certification: 5 Pending 1 Neturei i or Attending after death. Director: Aft 1 ☐ Yes 2 ☐ No Investigation 2 Accident the 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 D Homicide Hospital 24 hours Funeral edical 29e. Certifie 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and pieca, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the F within 2 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 0 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Philip Wisotsky, M.D. 700 Old Line Center #207 Waldorf, MD 32. Registrer's Signeture 31. Dete filed (Month, Day, Year) FEB 2 8 1997 Registrar

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08232 Certificate of Death 1. Decedent's Neme (First Middle Last) 2. Dete of Death **Physician** 1997 MARCH 4:20 pm ROY LEROY DENT /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner #6101 ROSE HILL ROAD MARSHALL CORNER CHARLES 6. Sax 12 M 2 ☐ F If Under 1 Yaar 5. Sociel Sacurity Number If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) 9. Birthpleca (Stet) Country) MARCH 27,1911 MARYLAND 7. Aga (In yrs. lest birthday) 9. Birthpleca (Stete or Foreign **Funeral** Months Deys Hours Yrs Director 218-30-4304 86 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 Yes 2 No Director MARYLAND CHARLES LA PLATA 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8 **Наты** 23a #6101 ROSE HILL ROAD 20646 UNITED STATES Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, Whita, atc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 'natural', or 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced BLACK Completed the Medical 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygen Important. If item 27 is marked other tha any injury or other traumatic LABORER MAINTENANCE Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nema (First, Middla, Maidan Sumeme) BERNARD DENT MARY GREEN HAWKINS 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) ANNIE SMOTHERS / SISTER 12488 HATTON CREEK ROAD, NEWBURG, MARYLAND 20664 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete Buriel 2 Crametion 3 Ramovel from State 4 ☐ Donetion 5 ☐ Other (Specify) ST. JOSEPH'S CHURCH CEM. 3/11/97 POMFRET, MARYLAND 21. Signifure of Funeral Sarvice Licansee 22. Nama and Address of Fecility route THORNTON FUNERAL HOME, P.A. 130IA C. THORNTON JO SON M00583 3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20640 Approximate Interval Between Onset and Deet Physician /Medical Immediate Cause (Final Arrythmen disaasa or condition rasulting in daeth) stunt Examiner Due to (or es e consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): physician s the burial P.O. Box 68760, Physician/Medicai Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 DUnknown ate hes been signed to page 2 should be dete Division of Vital Records, à Completed 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? certificate 1 ☐ Yas 2 ☑ No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical exeminar? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☑ Yes Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 2 No this 27. Menner of Deeth 28e. Dete of Injury (Month, Dev Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? After ! 1 Neturel 5 Pending 24 hours after death.

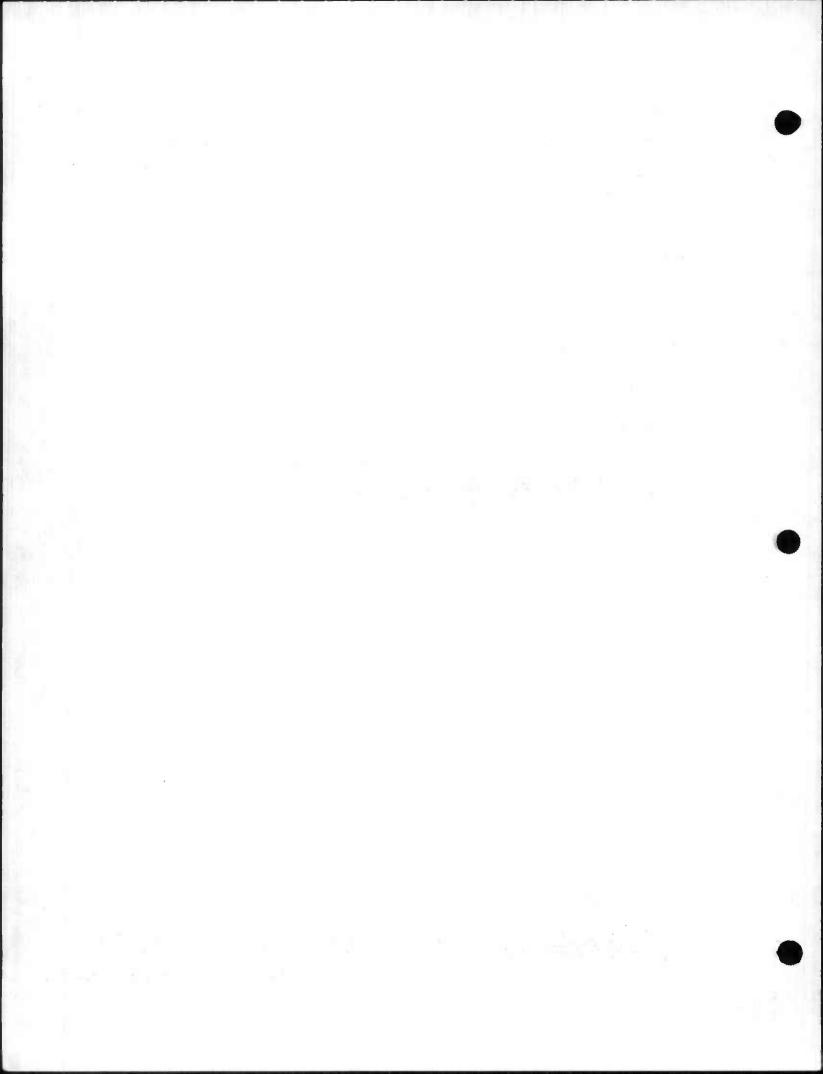
Funeral Director: A investigetion 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 | Homicide the Hospital 29e, Certifier 1 Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner steted. Medicai To the Hosp within 24 hos To the Fune completely fi (Check only one) 29b. Signature and title of costilies 29c. License number 29d. Date signed (Month, Dey, Year) MMD Deputy Med Exam. 30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print).

Charlene Letch ford MD 700 Old Line Centre #100 Waldorf NO 3060 2

State Registrar

31. Dete filed (Month, Dey, Year)

32. Registrer's Signetura Julia Stavolson Rardall



State of Maryland / Department of Health and Mental Hygiene

97

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					Cei	rtificate c	of Death		Reg. No.						
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Registrar

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Funeral Director		5. Social Security Number 578-05-722	r	nunity Ho 6. Sex 1□M 2X1F	spital 7. Age (In yrs. 76	last birthday Yrs.	ff Under 1 Year Months Deys	Lanha If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, Da 10/23/		9 Birtho	eorges iece (State or Foreign COUNTY, SC	
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28e	Director	10e. Street and Number					10f. Zip Code			10g. Citizen of	Whet Cour	itry?	
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			/	Me	_		D3	1069		March	6, 1	997	
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DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

12 a 12 octobril

7 is marked other than "natural", or items 23a of traumatic event, the Medical Examiner must be

permit. Peges 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" — none; in permitter than "natural" — none.

Physician /Medical

Examiner

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Physician/Medical

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

08235

							Cei	tificat	9 0	f Death		Reg	g. No.	1	00	C _{an}	00
Observatoria		1. Decedent's Nam	e (First, Midd	le, Last)								2. Dete of Deeth Month	Dev	Yeer	3. T	ime o	of Death
Physiciar /Medica	-	DAVID		EMEK	A			DIM	ВО			FEBRUAR		199	7	8:	15AM
Examine	-	4e. Facility Name (lf not institutio	n, give street end nu	ım <i>ber)</i>					4b. City, To	4b. City, Town, or Location of Deet			of Deeth			
		4409 2				3				TEMP	LE	HILLS	PRIN	NCE GEORGES			ES
uneral frector		5. Social Security N 219-35-		6. Sex 1⊠M 2□ F	7. Age	33	est birthday) Yrs.	If Under Months	1 Yea Day	-	24 Hrs. Min.	8. Date of Birth (Month, Dey.) March 22		9. Birthp Cour Nige	ntry)		or Foreign
		Usuei Residence o	Usuei Residence of Decedent														
28a-f show	101	Oa. State 10b. County 10c. City, Town of aryland Prince George's Temple												1			City Limits 2 □ No
r 28	5	10e. Street end Nu	mber					10f. Zip	Code			109	g. Citizen of V	Vhat Cour	ntry?		

4409 23rd. Parkway #t3

1 Never Married 2 Married

3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🖾 No If Yes, Give Yeer or Dates:

20748 13. Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2KNo Specify:

Nigeria Race - American indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) Coilege (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) Chef

16b. Kind of Business/Industry Food Industry

17. Fether's Name (First, Middle, Lest)

Chief Pius Amazou Dimbo

Benedeth Agbor

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)

19e. Informant's Name/Reletionship (Type, Print)

Josephine Dimbo / Wife

20b. Place of Disposition (Name of cametery, cremetory or other pleca)

4409 23rd. Parkway #T3 Temple Hills, Maryland 20748 20c. Location - City or Town, Stete

20a. Method of Disposition 1 ☐ Bunal 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify)

Oru LGA Imostate 22. Name and Address of Fecility

3/4/96 NIGERIA

18. Mother's Neme (First, Middle, Malden Sumeme)

21. Signature of Funeral Service Licensee 23a. Part 1. Enfer the disease, or complications they caused it shock, or heart failure. List only one cause on each line

Alexander S. Pope Funeral Homes

5538 Marlboro Pike/Forestville, Maryland 20747 caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, Approximete intervel Between

immediate Cause (Final diseese or condition resulting in death)

ntoxication

Due to (or as a consequenca of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Last

Due to (or as a consequenca of)

Due to (or es a consequence of)

Pert ii. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown

24e. Was en autopsy performed?

24b. Were autopsy findings evailable prior to completion of cause of death?

YYes

1 ☐ Yes 2 ☐ No

Onset end Deeth

25. Wes case referred to medical examiner? XX Yes 2□ No

27. Menner of Deeth

1 Neturei

2 Accident

3 Suicide

4 Homicide

5 Pending Investigation

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury
(Menth, Dey Year) 28b. Time of 7:45 AM 2/20/97

28c. Injury et Work? 1 ☐ Yes 2 K No

Other: 4 Nursing Home XX Residence 8 Other (Specify) 28d. Describe how Injury occurred

26. Place of Death (Check only one)

unknown

29a. Certifier (Check only one)

6 Could not be determined

28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) Home

281. Location (Street and Number or Aurel Route Number, City or Town, State) 23 5 Pkwy T3 Temple H. W. , HD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piace, end due to the cause(s) and menner as steted.

**Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated.

29b. Signeture and title of certifier

29c. License number

29d. Dete signed (Month, Day, Yeer)

O.C.M.E.

FEBRUARY 27, 1997

30. Neme end eddress of person who completed cause of deeth (item 23a) (Type, Print)

M.D. DENNIS J. CHUTE 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Dey, Year) MAR 03 199

State Registrar 32 Registrar's Signeture Mudear

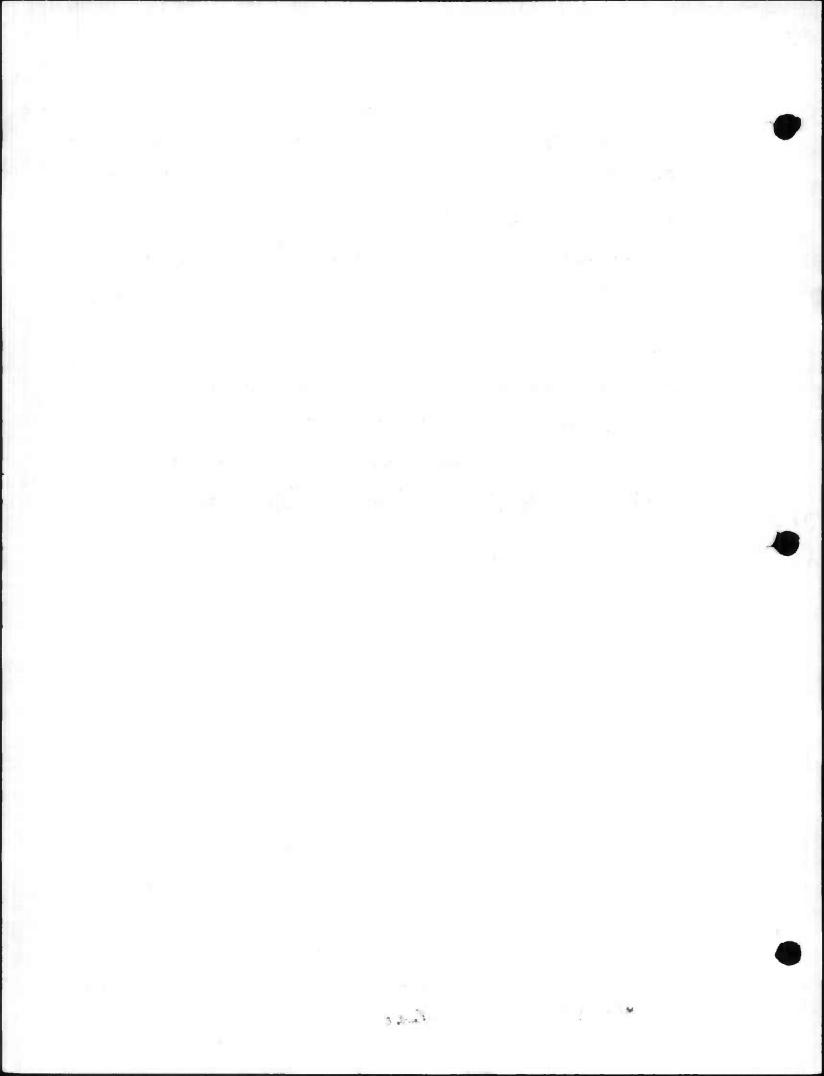
DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760

requires that the death certificate be axecuted

Attending Physician: aftar death Director:

To the Hospital or Atter within 24 hours aftar der To the Funeral Director completaly filled in by th



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 28,1997 **Physician** Philomena Dalesandro 7:20p.m February /Medical 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Fort Washington Hospital 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** 10 M 25 F 97 214-68-8944 Yrs. Director Feb.6, 1900 Italy Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at YdYes 2 No Director Maryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 U.S.A. Funeral 6616 March Dr. 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ② No if Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Rece - American Indien, Black, White, atc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 N Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "reny injury or other traumetic event, the Heal Collega (1-4or 5+) Elemantery/Secondary (0-12) Housewife At home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middla, Malden Surneme) Michael Casullo Anna Schaveone 19e. tnforment's Neme/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 6616 March Dr., Oxon Hill, MD 20745 Michael Dalesandro/Son 20b. Pleca of Disposition (Neme of cematery, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Buriel 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 3/4/97 Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Nama and Address of Fecility George P. Kalas Funeral Home 6160 Oxon Hill Rd., Oxon Hill, MD 20745 Eaftar the disease, or complications thet caused the deeth. Do not antar tha mode of dying, such as cardiec or respiratory arrest, bock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examine Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in deeth) Lest Due to (or as e consequence of): Records, P.O. Box 68760, Physician/Medical 4 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? B PUEUMONIA; HYPERTENSION 1 Yee 2 No 3 Probably 4 Unknown 8 24b. Wera sutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical å 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 Inpatient 2 ER/Outpetlent 3 DOA 100 27. Menner of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After completely Illed in by the fune 1 Netural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: d in by the 6 Could not be datermined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide 29a. Certifie 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piece, end due to the cause(s) end menner es steted.
2 Medical Examinar: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner steted. Medical 29b. Signetura and title of cartifier 29c. Licanse number 29d. Date signed (Month, Day, Year)

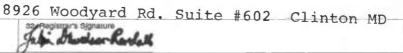
State Registrar

31. Dete filed (Month, Day, Year)

MAR 04 1997

Louis Kaufman

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)



Physician /Medical Examiner The law requires that the death certificate be asscuted

2

1/1

Physician

/Medical

Examiner

Funeral

Director

28a-f show must be notified at

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Hems 2

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"natural",

should be filed within 7 and Mental Hygiane.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if flem 27 is marked othe any linjury or other traumatic event anse.

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Director

by

Completed

Examiner Physician/Medical þ Completed Be

physician and s the burial-tran signed b page 2 s certificata at or Attending Physicien: The safter death.

It Director: After this certificated in by the funeral director, pa Certification: To

Division of Vital To the Hospital within 24 hours a To the Funeral C edicai

State Registrar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical niner? examiner? 1 XYes 2 □ No 28a. Mate of Injury (Month, Dey Yeer) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 8b. Injury 09:54 PM 1 Natural 5 Pending SUBJECT SHOT SELF 1 ☐ Yes 2 No Investigation 2-25-95 2 Accident 3 X Suicide 4 ☐ Homicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) FRIENDS HOME 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 1407 EARLY OAKS LANE, CHAPEL OAKS 29a, Certifler 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) end manner as steted Medical Examiner: On the besis of examiner steted. aminetion end/or Investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) 29c, License number
PEPUTY MEDICAL EXAMINER 29b. Signature end title of cartifier 29d. Date signed (Month, Day, Year)

D33954

FEBRUARY 27, 1997

GOLLE JR M.D. 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785 31. Date filed

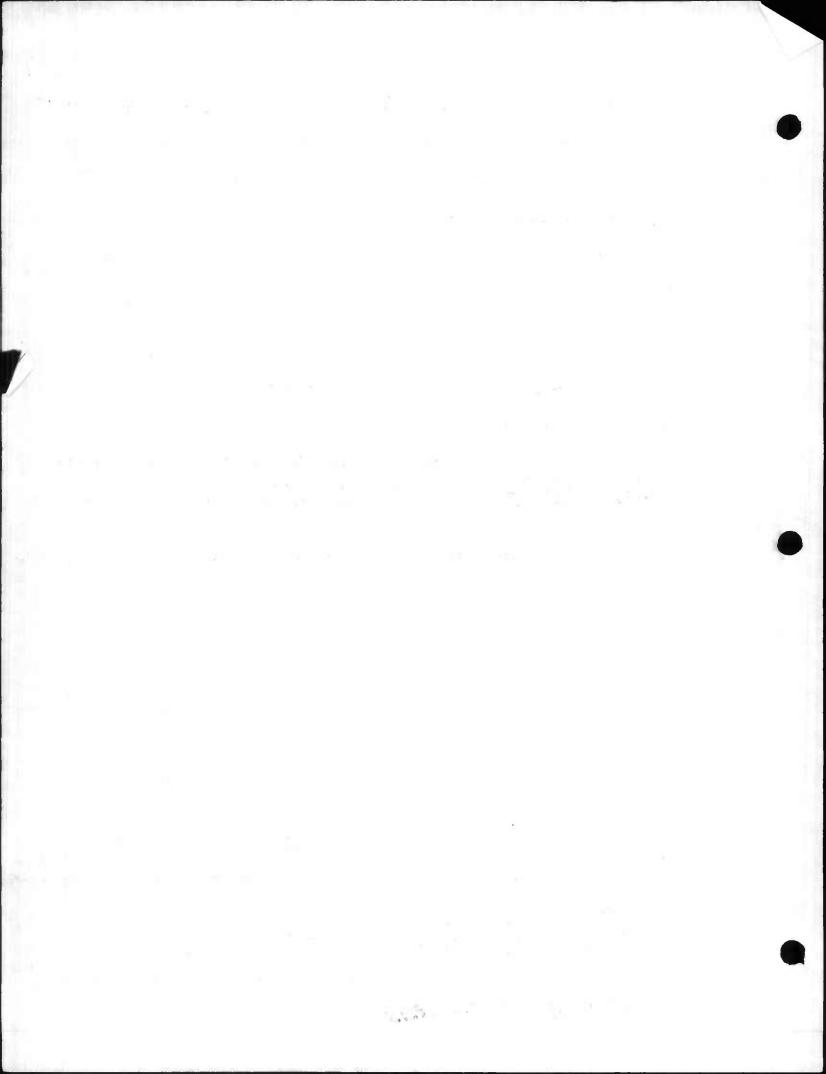
F.

30. Name and address of person who

MARIO

Aegistrar's Signature

ed cause of death (form 23a) (Type, Print)

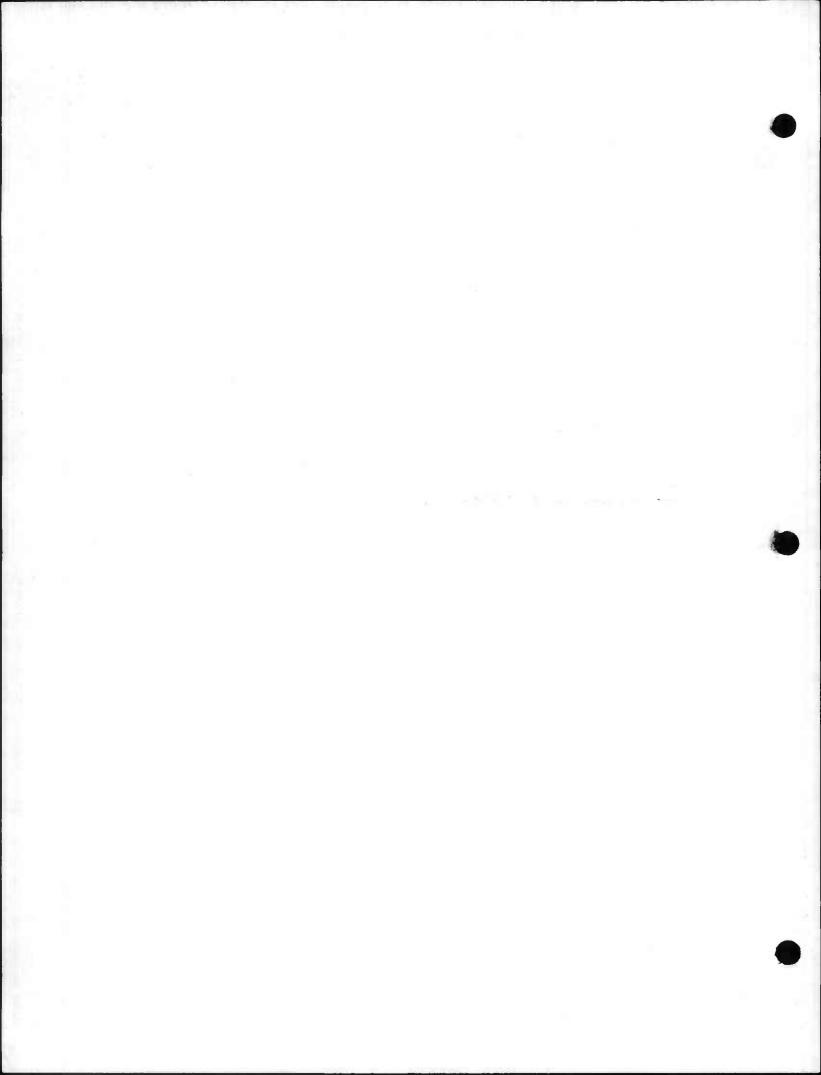


State of Maryland / Department of Health and Mental Hygiene 08238 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** SZEREN ELFENBEIN FEBRUARY 1997 7:38 AM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth **Examiner** SUBURBAN HOSPITAL **BETHESDA** MONTGOMERY | Months | Deys | Hours | Min. | NOVEMBER 11, 1915 5. Sociel Security Number 9. Birthplece (State or Foreign Country) 15 HUNGARY 7. Age (In yrs. last birthdey) **Funeral** 1□M 2XF 088-40-1316 Yrs. Director Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City. Town or Location show 10d. Inside City Limits Director 1 Ves 2 □ No 288-1 MARYLAND MONTGOMERY ROCKVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8 must be Berns 23a 6121 MONTROSE RD 20852 UNITED STATES Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Meritel Status Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. hours after 1 Never Merried 2 Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: P Specify: 3 ₩ Widowed 4 Divorced 'natural', WHITE Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental: Important: If Item 27 is marked of any injury or other treamatic ever Pages 1 and 2 should be nent of Health and Mental ZALMEN LOWY. HAIE SCHWARTZ 0 19a. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) ANIKO JACOBOVITS 12025 MONTROSE VILLAGE TERRACE ROCKVILLE MARYLAND 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) FLORAL PARK CEMETERY | O2Mar97 | DEANS, NEW JERSEY 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility
DANZANSKY-GOLDBERG MEMORIAL CHAPEL, 1170 Rockville Pike Rockville, MD 20852 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Finel diseese or condition resulting In deeth) Examiner Physician/Medical Examiner The lew requires that the deeth certificate be executed buriel-tren Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In deeth) Lest Due to (or es e consequence of): Box 68760. Con Cor 2 the Due to (or es e consequence of): P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown signed to be det Records. þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24a. Was an eutopsy pege 2 s 1 Yes 2 No 1 Yes 2 No of Vital or Attending Physician: Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2€ No 2 ER/Outpetient 3 DOA this the funeral 27. Mennes of Deeth 28e. Dete of Injury (Month, Day Yeer) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Affer Division 5 Pending Investigation 1 Neturel 1 Yes 2 No within 24 hours efter death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, State) filled in by 4 Homleide Hospital 1 Certifying Phyeiclan: To the best of my knowledge, death occurred et the time, dete and plece, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner steted. Medical 29a, Certifier completely the 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) Munter, Sanker flower 30. Name end eddress of person who completed cause of deeth (Item 23a) Type, Print) 2401-RESEARCH BLID, ROCKITE, MARYLAND -20850

32. Registrery Signeture

DHMH 16 Rev 6/95

State Registrar 31. Dete filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Decedent's Nama (First, Middle, Last)		1 3		tificate of	Death	2. Date of De	Reg. No.	7 0823
Physicia /Medica	_	ELEANOR	CORSO		ENDE	ERLIN		Month FEB.	28, 19	3. Time of Dea 97 8:45 I
Examine	er	4a. Facility Name (If not institution, give st MANOR CARE N					4b. City, Town, or CHEVY	CHASE	MONT	Death GOMERY
Funeral Director		5. Social Security Numbar 6. Sex 1.39-03-0044 Usual Residence of Decedent	7. Ag	ge (In yrs. las 81	t birthday) Yrs.	Months Days			th ny, Year) , 1915	9. Birthplace (State or For Country) PA
anyland show dat	-	10a. State 10b. County		10c. City, 7	Town or Loc					10d. Insida City Lir
the Maryla 28a-f show notified at	recto	MD. MONTGON	ÆRY		BE	THESDA 10f. Zip Code			10g. Citizen of Wh	Yas 2
23s or	O E	4411 ROSEDAI	-F ΔVF				0814			S.A.
. 05	by Funeral Director		2. Was Decedent Armed Forces? 1 Yas 2 X If Yes, Give Year or Dates:	Ever in U.S.			Hispanic Origin? (S ban, Mexican, Pue	Specify Yes or No to Rican, etc.)		American Indian, White, etc.
*natural,	eted	15. Decedent's Educa (Specify only highast grade of	tion	1		ent's Usual Occu	petion during most of wo	ndina	16b. Kind of Busi	
d within piens. r than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Tife. D	ONOT use retin	9d)	nnig	АТ	HOME
三五台号	Bec	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle	, Maiden Sumama)	
	2	WILLIAM		SON				KATE	STAN	
がおる場		19e. Informant's Name/Relationship (Type							er, City or Town, St	209
if item or oth	-	WILLIAM O. END! 20a. Method of Disposition 1 □ Burial 2 【Cremation 3 □ Ref		20b. Plac	1021 e of Dispos etery, crem	ition (Name of atory or other pla		Date	20c. Location - Ci	R SPRING, M ity or Town, Stata
artment ortant: Pag ortant: I injury o	-	4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service Licensee	1 13	CHA		S CREM		3/4	RIVERI	DALE, MD.
Onepa fimpo anny l		ER SPRI	NG, MD. 20910							
Physician /Medical Examiner	e.	Immediate Ceuse (Final disease or condition resulting in death) a	A. ther	Due to (or as			· Disea	se		Interval Between Onset end Death
physician end sthe bunal-transit	edical Examin	Sequantially list conditions, if any, leading to immediate causa. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as						
5 00	-	d								
he atte	Physician/M	Part II. Other aignificant conditions contri	buting to death b	ut not resultin	g in the und	derlying cause gi	iven in Part I.	23b. Did	tobacco use contr	ibute to the cause of dea
and by the and detached to Physical	Dy Find	Branc . Preumoni	۷.			_		10	Yes 2□ No 3	Probably 4 Unkr
2 should	peted	Bronc. Preumoni Care Sno Voscula	Accio	lent				24a. Was perfo	en autopsy med?	24b. Were autopsy finding available prior to completion of cause of death?
ate h	5							10	res 20 No	1 ☐ Yes 2 ☐ No
this certificate	ן מ	25. Was case referred to medical examiner?	spital:			Ot		ath (Check only o		
5 6	- -	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatie 28a. Date of Inju (Month, Da	ry 28	Outpatient b. Time of Injury	28c. Inju	4 La Nursing I		dence 6 Other	
a Director: After the ed in by the funerel	erillica	3 □ Suicide 6 □ Could not be	28e. Place of Injuding, etc.	ury - At home c. (Specify)	, farm, stree			28f. Location (: City or Tox		or Rural Route Number,
within 24 hours effect to the Funeral Director completely filled in by the Medical Certific		29a. Certifier (Check only one) 1 Certifying Physics 2 Medicat Examiner	an: To the best of On the basis of and manner sta	examinetion	dge, death o and/or inve	occurred et the ti stigetion, in my	me, date and plece	a, and due to the urred at the time,	cause(s) and mann date and piece, and	er as stated. d due to the cause(s)
within To the comple		29b. Signature and title of certifier				29c. Licen			29d. Date signed	Month, Day, Year)
30		1 telle	W_	Jan			12333	157	3/3/5	7
		30. Name and address of person who comp Lee Jene Ha Mu	pleted cause of d	eath (Item 23	e) (Type, P	rint)				Leng Chare h
State Registrar		31. Dete filed (Month, Dey, Year) MAR 0 4 1997	32. Registra	ar's Signature	-Aande	Wiscon	sin Hu	- Juite	1045 C	henry Ch

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State of Maryland / Department of Health and Mental Hygiene 08240 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Dete of Deeth Month Vear **Physician** 1349 MARGARET VIRGINIA EVERETT 1997 March /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital of Cecil County Elkton Cecil 5. Social Security Number If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 1□M 25F 76 Director 220-01-3135 June 23 1920 Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shot traumetic event, the Medical Examinar must be notified at the Maryle DE. New Castle 1 ☐ Yas 2 ☒ No New Castle Director 10f. Zip Code 10g. Citizen of What Country? 31 Paul Rd. Chelsea Estates 19720 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Dacedani of Hispenic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Bieck, Whita, atc. Pages 1 and 2 should be filed within 72 hours after of their of Health and Mental Hygiens.
Int: If fleen 27 is marked other than "natural", or itse 1 ☐ Yes 2 ☑ No If Yas, Giva Yeer or Detes: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: à Specify: White 3√ Widowed 4 Divorced Completed 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 18b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) Waitress Restaurant 18. Mother's Neme (First, Middla, Meiden Sumame) 17. Fether's Nema (First, Middle, Last) Albert L. Cummerford Jenny C. Benson important of Health and Important: If hem 27 is re-any injury or other traums gods. 19e. informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Jenny Carroll (cousin) 116 Park Circle Elkton, MD. 21921 20e. Method of Disposition 20b. Piace of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) 3/10/97 Massey Cemetery Massey, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility M00510 Galena Funeral Home of Stephen Schaech 23a. Rest. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or hyari failure. List only one ceuse on each line. **Physician** /Medical Immediete Cause (Finel disaasa or condition rasuiting in death) Ischemie ordio my opathy 154rs Examiner Due to (or as e consequence of) sician and burial-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events rasulting in deeth) Last Due to (or es e consequance of): physician s s the bunal Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es e consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b, Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown Severe chronic obstructive lung disease þ 24b. Wara autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 7.5 cm Aorbie Anewysm 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific funeral director, 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) examiner? Hospitel: 1 Thpatient Other: 4 Nursing Home 5 Residence 8 Othar (Specify) 10 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending invastigation 1 Natural 1 Yas 2 No 2 Accident filled in by the 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Pieca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide edicai 1 🖫 Certifying Physician: To the best of my knowledge, deeth occurred et tha tima, data and piaca, end due to the cause(s) and menner as steted. 29a. Certifier (Check only one) 2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the tima, deta and pieca, and due to the cause(s) and menner steted. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 007129 March 7,1997 wallow Chempian mi 12 30. Neme end eddress of person who completed causa of deeth (item 23e) (Type, Print) Cecilton, md. 21913 BENJHAIN 1mD WALLACE 31. Dete flied (Month, Dey, Year) 32. Registrar's Signetura State de lia Davidson-Randelle MAR 1 1 1997 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

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miner	4a. Facility Name (If not institution, green Convo. 5. Social Sacurity Number 6.	ve street and numbar)	2. 60				Month	27 1	997	210 A
r	Social Sacurity Number 6.	descent	Cen	ier	4	b. City, Town, or	Location of Deat		y of Death	undol
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0	10e. Street and Number	George S	Bowi		f. Zip Code			10g. Citizen of	What Coun	try?
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by	11. Marital Status 1 □ Naver Married 2 □ Married 3 ঐ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Yaar or Dates:			specify Cuba	spanic Origin? (n, Mexican, Puei Specify:	Specify Yas or No to Rican, etc.)	Specia	ca - Amarica ick, Whita, a fy: Whit	atc.
Completed	15. Decedent's E (Specify only highast gi Elemantary/Secondary (0-12)	ducation ade com <i>pleted)</i> Coilage (1-4or 5-	+)	life. DO NO	of work done of OT use retired	furing most of we	orking	16b. Kind of E		
Be Co	12 17. Father's Name (First, Middle, Las	1)		Homema	ker	18. Mother's Na	me (First, Middle		Home_	
To B	Philip Martin	ez				Anna	Wisenbu	rger		
	19a. Informent's Name/Relationship Dorothy A. Twohi		19				ural Route Numb			
	20a. Method of Disposition		20b. Placa	of Disposition ory, crematory			ive Bow	1e Mary. 20c. Location		
	1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	Removal from State		ary Cei		1	h 3, 19			
Miles	21. Signature of Funeral Service Lica	nsee	0427	22. Nam Robe:	e and Addres	s of Facility Evans Fu	neral H	ome, Ind	2.	
n al	2 Part1. Enter the dise se, or consider the disease. List only limited the cause I in a list of the cause of condition resulting in deeth)	a. Pu	L MoNA	RY E	MBOLU		c or respiratory a	rrest,	1	Approximata Interval Between Onset and Death
al Examiner	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events	b. <i>DE</i>	EP VE Due to (or as a	Consequence	HROMA of):	0315.				3 MONTH
an/Medical	resulting in death) Last	d	ue to (or as a	consequance	of):				1	
Physician/	Part II. Other significant conditions	contributing to death but	not resulting i	n the underlyl	ng cause give	en in Part I.		/		the cause of de
by Ph							10	Yes 2DNo	3 Prob	ably 4 Unk
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o Be	25. Was case referred to medical examiner? 1 ☐ Yas 2 ☑ No	Hospital:			7 DOA Othe		ath (Check only			
	27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury (Month, Day		utpatient 3	28c. Injury Work	4 Mursing I	doma 5 Resi	danca 8 ∐Oti how injury occu)
Certification:	1 Maturel 5 Pending 2 Accident Invastigatio 3 Sulcide 8 Could not be determined	n e co- Stand (Literatur	v - At home, fe	Injury M erm, street, fa	101	/es 2□No	28f. Location (City or To	Street and Num wn, State)	ber or Rural	Route Number,
edical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	nysician: To the best of niner: On the basis of e and menner stete	examination en	e, death occur id/or Investiga	rred et the tim ition, in my op	e, date and place Inlon, deeth occ	e, and due to the urred at the time,	cause(s) end m date and place,	anner as sta and due to	ated. the cause(s)
M	29b. Signatura and titla of certifiar				29c. License			29d. Date signe		
	* KULLIA) MD	- AL 700	7	D503	43	UTE A-	Februa	y 28	,1997
	30. Name and address of person who KBLVIN HAO		ath (Item 23a) 23/ 51	(Type, Print)	2 , 4 .	16 11	UTF 4-	-6 BA	WIF	2071

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month ald man AMRAIM marche 2 1997 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County ot Death Montgomery General Olney Montgomery If Under 1 Year If Under 24 Hrs. Months Deys Hours Min. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) P. Birthpiece (State Country) Apr. 10, 1957 Georgia 7. Age (In yrs. lest birthdey) Birthpiece (State or Foreign Country) 12M 20F 39 Yrs. 255-31-6472 Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery Silver Spring 1 Yes 2000 10e, Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20902 United States 1000 Lamberton Dr. 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2≦ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) 5+ Attorney Private 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Emanue1 Feldman Estelle Samber 19e. Intorment's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Gloria Feldman/ wife 1000 Lamberton Dr. Silver Spring, Md. 20b. Piece of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Buriei 2 □ Cremetion 3 □ Removel from State 3/3/97 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) UNITED HEBREW CEMETERY 21. Signeture of Funerel Service Liongel 22. Neme end Address of Fecility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, Md. Pert 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tellure. List only one cause on each line. Approximete Intervel Between Onset end Deeth myocardes immediate Ceuse (Finel diseese or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evaileble prior to completion of cause of deeth? 24a. Wes an eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Wes case reterred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending 1 Yes 2 No investigation

Examiner The law requires that the death certificate be executed Records, P.O. Box 68760. the is certificate hes been signed by the a director, page 2 should be detached After this certificate Division of Vital al or Attending Physician: The setter death. filled in by the

Physician/Medical Certification:

Physician

/Medical

Examiner

Funeral

Director

mant be notified at

28a-1

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238

Herra:

"natural", or

Important: If Item 27 is marked other any injury or other traumatic event, if

Physician /Medical

Examiner

Pages 1 and 2 should be nent of Health and Mental

filed within 72 hours after

Baltimore, Maryland 21215-0020

Director

Funeral

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Be Completed

ģ Be Completed 2

Medical

State

Registrar

27. Menner of Deeth 1 Naturel

2 Accident 3 Suicide 4 Homicide

29a. Certifler

6 Could not be determined

28e. Piace of injury - At home, ferm, street, tactory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and mainten as stated.

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the ceuse(s) and menner stated. (Check only one) 29b. Signeture end title of certifier

Cus

💶 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end manner as steted.

D085

8218 W. Scansin

29d. Dete signed (Month, Day, Year)

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

YN 31. Dete tiled (Month, Dey, Year)

MAR 0 5 1997

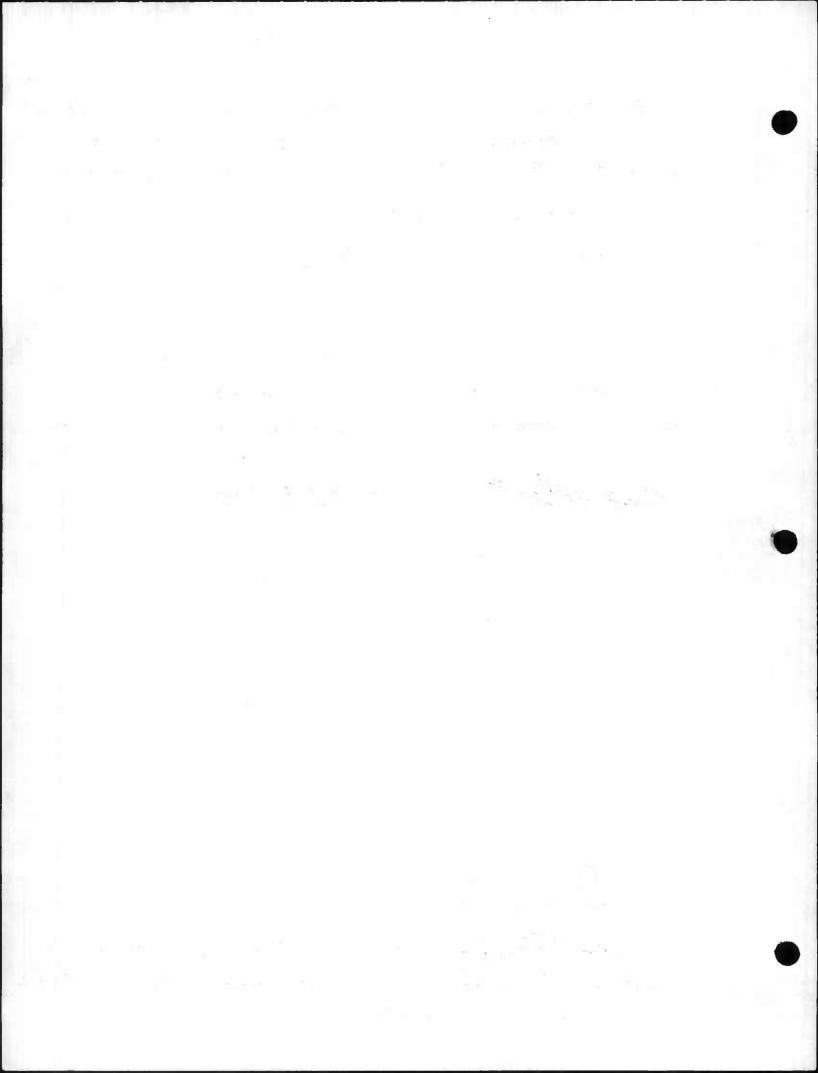


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Hospital of 24 hours e To the Hospital within 24 hours e

1997

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/Med Exam		4e. Fecility Neme (If not institution, git 594 HOLLYBERR					4b. City, Town, o	r Location of Dee	th 4c. County		1555 11	
Funera Directo			Sex 7. Age 1 □ M 283 F	(In yrs. lest b	Yrs. If Und Month	er 1 Year Deys			irth Day, Year)	9. Birthplece Country) MARYI	(State or Foreign	
5-0020 72 hours after death with the Maryland natural; or thems 23s or 28s-f show aless Examines must be notified at	ctor	Usuet Residence of Decedent 10e. Stete 10b. County MARYLAND FREDERI	CK		wn or Location DERICK					10d.	Inside City Limits	
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yland ould be file Mantel Harked oth arked oth	Be	17. Fether's Name (First, Middle, Last								Meiden Sumeme) NISENFELD		
Maryland 42 should be file h and Mantel Hy 7 le marked oth traumatic event	5			10	h Melling Addre	es /Strae						
Martrau			ormant's Neme/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, 2 ENA FORSTER (MOTHER) 5225 POOKS HILL ROAD #1726N BETHESDA, M									
Baltimore, Normal Pages 1 and Department of Health Mortant: If Item 27 Inty Injury or other trans.		20e. Method of Disposition 1 St Buriel 2 Cremetion 3	office Manager It is ther's Name (First, Middle, Last) OFFICE Manager 18. Mother's Neme (First, Middle, Meilor Name) OR. STANLEY FORSTER Informant's Neme/Relationship (Type, Print) DENA FORSTER (MOTHER) Method of Disposition OR STANLEY FORSTER OFFICE MANAGER 18. Mother's Neme (First, Middle, Meilor Name) OENA OENA OFFICE MANAGER 19b. Melling Address (Street end Number or Rurel Route Number, Company) OENA OENA OFFICE MANAGER 10b. Melling Address (Street end Number or Rurel Route Number, Company) OENA OENA OENA OFFICE MANAGER 10b. Melling Address (Street end Number or Rurel Route Number, Company) OENA							City or Town,		
Baltimol Berlin Pages Department of Important: if is any injury or once		23e. Pent1. Enter the disease, or comshock, or heart feilure. List only Immediate Ceuse (Final disease or condition resulting In death)	iplications that caused one ceuse on each line NARCOTIC e.	[MEPERI	DANZA 1170 not enter the me	NSKY ROCK ode of dy	VILLE PI ing, such as cardi	KE ROCKY	IAL CHAP: VILLE, MA errest,	ARYLAND	IC. 20852 proximete erval Between sset and Death	
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68760, ifficate be executed g physicien and as the bunal-transit	icai Exam	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	C		consequence of							
X cer	in/Medic	that initiated events resulting in deeth) Lest	d	Due to (or es e	consequence of):				1		
P.O. hat the detached	by Physician/Med	Pert It. Other significant conditions of	contributing to death but	t not resulting	In the underlying	cause gi	ven in Pert I.				e cause of death?	
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To the Hospital within 24 hours a To the Funeral I completaly filled	edicai	29a. Certifier 1 Certifying Pr (Check only X2X Medical Examone)	ysician: To the best of niner: On the basis of and manner state	exeminetion e	e, deeth occurre nd/or investigation	d et the ti n, in my	me, date end ple opinion, deeth oc	ce, end due to the curred et the time	e ceuse(s) end me e, dete and pleca,	enner es stete and due to the	d. e cause(s)	
the second	ž	29b. Signeture and title of certifier	10/11		2	c. Licen	se number		29d. Date signe	d (Month, Dey	, Year)	

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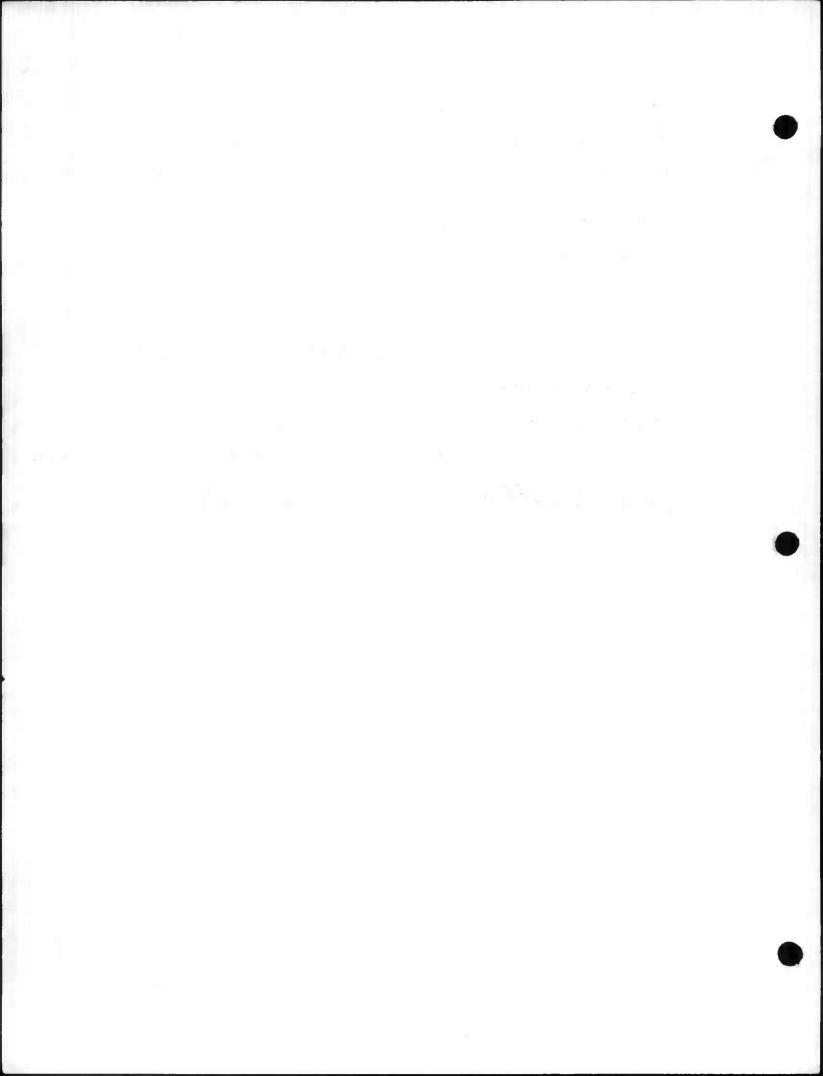
MARCH 4, 1997

30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print)

| Will Revenue 111 Penn Street, Baltimore, Maryland 21201

State Registrar





State of Maryland / Department of Health and Mental Hygiene Ct Certificate of Death JW. Monta. 17, 3/7/97, per F.H. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death **Physician** Month Vear Hyman 22, Fineman FCB /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** Mariner Nursing Home Silver Spring Montgomery 7. Age (In yrs. lest birthdey). 85 Yrs. If Undar 1 Yaar If Undar 24 Hrs.
Months Days Hours Min. 5. Social Sacurity Number Data of Birth (Month, Dey, Year)
Nov 20, 1911

New York **Funeral** Days 10 M 20 F 107-09-5081 Director Usual Residence of Decedent the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits a 28a-f show 1 ☐ Yas 2 ☑ No Director Montgomery Silver Spring 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? Herne 23a or event, the Medical Examiner must be 901 Arcola Ave 20902 United States permit. Pages 1 and 2 should be filed within 72 hours after death. Department of Health and Mental Hygiene. Important: it item 27 is marked other than "natural", or Items 23s any injury or other traumatic event the 11. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Giva Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White g Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Pharmacist. 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Meiden Sumema) Be Fineman King Morris Bessie Shapiro 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Harvey King 14609 Stone House Ct. Silver Spring, MD 20905 20b. Place of Disposition (Name of cematary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Removal from Stata 1 X Burial 2 ☐ Cremation King David Memorial Gar. 2/26 Falls Church, VA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852 Part Chlardie distance complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final a Aspiration Pneumonia disaasa or condition rasulting in death) 3 Days Examiner Due to (or as a consaquence of): Examiner buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Diseasa or injury that initiated events resulting in death) Last Dua to (or as a consequence of): physician the buriel Box 68760. The lew requires that the deeth certificate be Physician/Medical Due to (or as a consequence of) ettending lor Part II. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. the been signed by should be detac 1 ☐ Yee 2 ☐ No 3 ☐ Probebly 4 ☒ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed hes page 2 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Was case rafarred to medical axaminer? 28. Place of Death (Check only ona) Other: 4⊠ Nursing Homa 5 ☐ Rasidenca 6 ☐ Other (Specify) 1 Yes 2√ No 1 Inpatiant 2 ER/Outpatient 3 DOA funeral 27. Manner of Death Certification: 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No Investigation 2 Accidant 8 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, atreet, factory, offica building, atc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D Completely filled I 29a. Certifier 1🔀 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D09834 2/23/1997 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

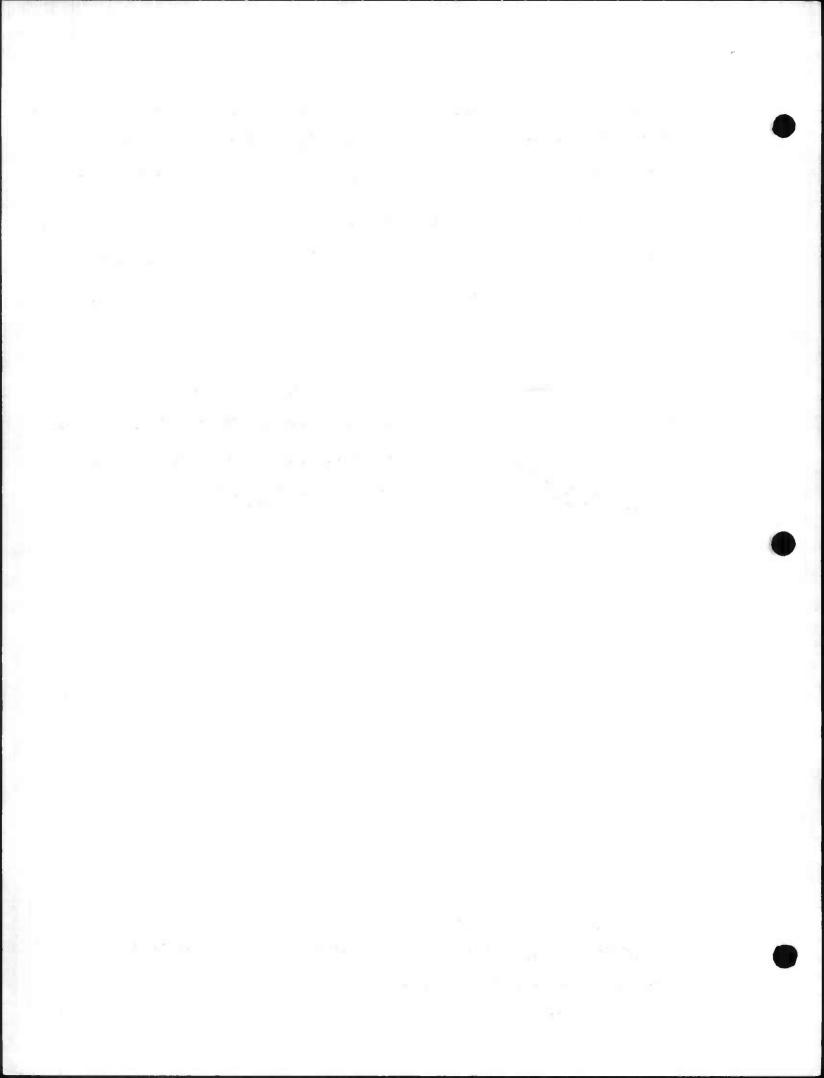
Barry Rosenbaum 3720 Farragot Kensington, MD 20895

32. Registrar's Signature

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

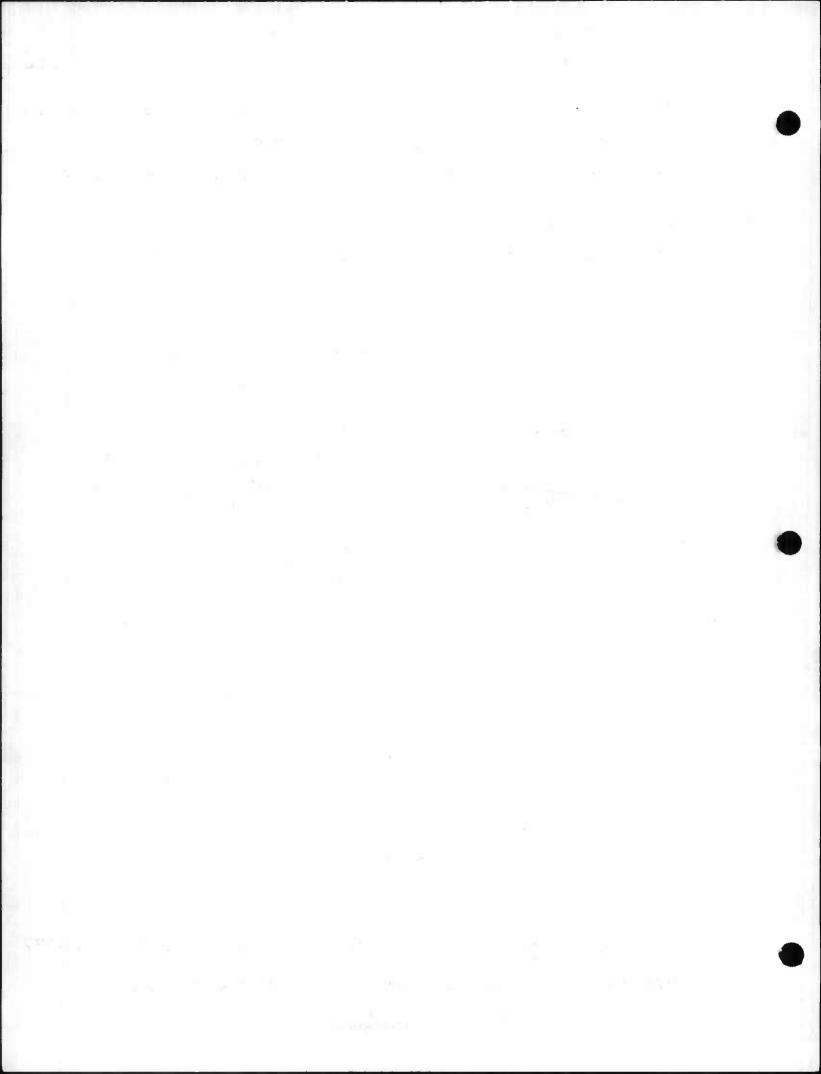
FEB 2 6 1997



State of Maryland / Department of Health and Mental Hygiene

08245 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** SARAH MADELEINE FAHY 9:00 P.M. FEBRUARY 27, 1997 /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MANOR CARE POTOMAC MONTGOMERY 5. Social Sacurity Number if Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) 9. Birthpiece (Stete or Foreign Country)
APRIL 10,1894 ROME, GEORGIA 6 Sax 7. Aga (In yrs. last birthday) Birthpiece (State or Foreign Country) **Funeral** Deys Hours Min 1 M 2 F Yrs Director 258-01-6550 102 Usuei Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MARYLAND MONTGOMERY POTOMAC 10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? WITH 5 items 23a 10714 POTOMAC TENNIS LANE 20854 U.S.A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ⑤ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 14. Reca - Amarlcan Indian, Black, Whita, etc. filed within 72 hours efter 1K Navar Marriad 2 Married 5 21215-0020 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify "natural", WHITE Completed 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use ratired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grede completed) el Hygiene. Fiamentery/Secondary (0-12) Coilege (1-4or 5+) 12 HOMEMAKER OWN HOME traumatic event. Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surneme) d 2 should be fi h end Mentel H 7 is marked ott Be THOMAS FAHY SARAH JONES 0 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 end 2.
Department of Health er
Important: If item 27 is
any injury or other trau ANNE F. SHEEHAN/NIECE 10008 BELHAVEN ROAD/BETHESDA, MD 20817 20b. Place of Disposition (Name of cematery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, State Data 1 Buriei 2 Cremetion 3 Removel from Steta 3/3/97 MYRTLE HILL CEMETERY ROME, GEORGIA 4 □ Donetion 5 □ Other (Specify) 22. Name end Address of Fecility Joseph Gawler's Sons, Inc. 5130 Wisconsin Avenue, NW Washington, D.C. 20016 21. Signeture of Fugerel Service Licansaa ele 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heer failure. List only one causa on each line. Approximate Onsat and Death **Physician** /Medical immediete Ceusa (Finai disaesa or condition resulting in death) Examiner Examiner The law requires that the deeth certificete be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last Due to (or es e consequança of): physician a Box 68760. Physician/Medicai Dua to (or as a consequence of) signed by the etter Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. Division of Vital Records, P.O. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peen hes 1 ☐ Yes 2 No certificate : or Attending Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4X Nursing Home 5 Residence 8 Othar (Specify) 2 1 Yes 2 No this 27. Menner of Death 28e. Deta of injury (Month, Day Year) 28d. Dascribe how injury occurred Certification: 28b. Tima of 28c. Injury et Work? After 5 Pending investigation 1 Naturei death. 1 Tyes 2 No 2 Accident efter death Director: 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Spacify) 3 4 Homicide within 24 hours oft To the Funeral Dis completely filled in Hospital edicai 29e, Certifier 🌊 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date and place, and dua to the ceuse(s) end mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, dete end pieca, end due to the cause(s) end menner steted. 29b. Signetura end titierof on 29c. Licensa number 29d. Date signed (Month, Dey, Year) FEBRUARY-28-1997 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) SWAROOP G. RAO, M.D. 50 W. EDMONSTON DR. #504, ROCKVILLE, MD 20852-1228 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar Julia Davidson Bondall

DHMH 16 Rev 6/95

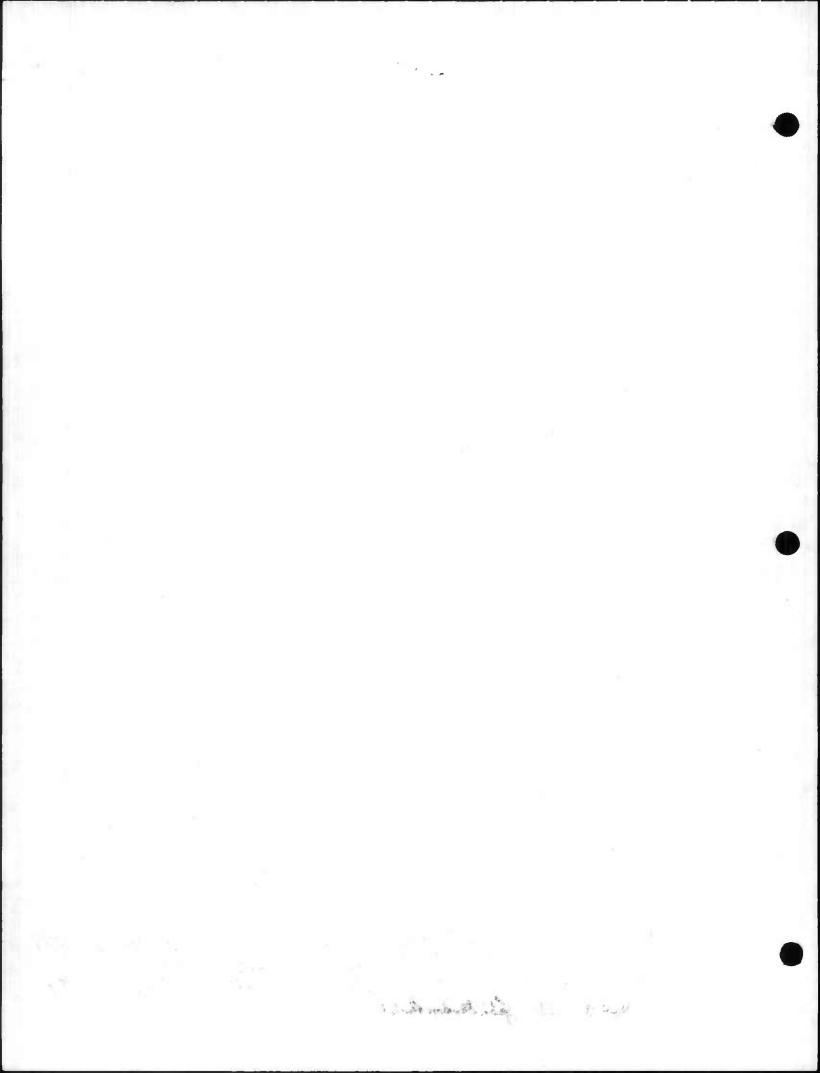




State of Maryland / Department of Health and Mental Hygiene

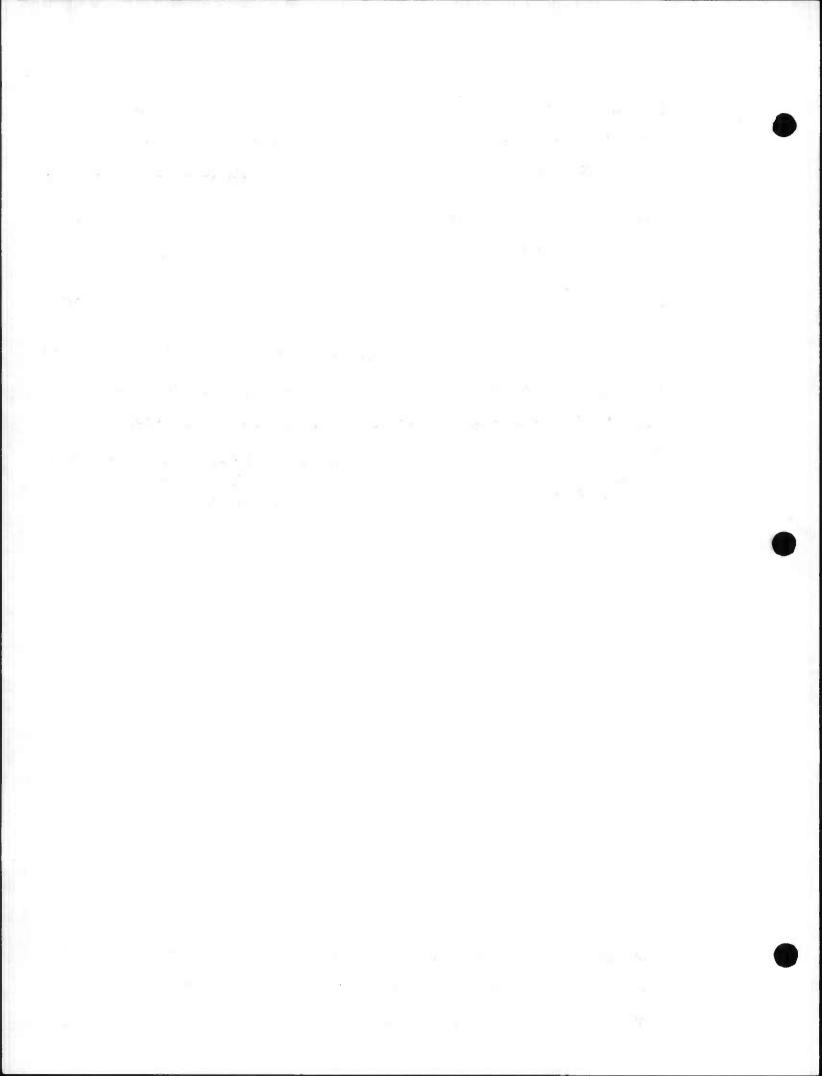
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					N	'Cer	tificate c	of Death	7	Re	g. No.		000	. 70
			1. Decedent's Name (First, Middle	, Last)					I	2. Dete of Deet	1		3. Time of	f Death
	Physic		CYNTHIA JEAN	FORD						Month Februar	y 28,	Year 1997	3:30	P.M.
	/Medi Examii		4e. Fecility Nema (If not institution,					4b. City, T		cation of Death	4c. County		3.50	,
	LAGITIN	161	744 High Plain I					Ro1	Air			ford		
-	Francis				e (In yrs. lest b	irthday)	If Under 1 Ya			8 Date of Birth			olece (Stete o	or Foreign
	Funeral Director		213-52-5541	1□M 2⊠F	48	Yrs.	Months Day		Min.	8. Date of Birth (Month, Day, Oct. 30,	Year)	Coun	Vland	or Foreign
			Usual Residence of Decedent		40				1		1940	Pict	.yıana	
	and w		10e. Stete 10b. County		10c. City, Tox	wn or Lo	cation					1	0d. inside Ci	ity Limits
	Aary sh	0	Maryland Har:	ford	Po1	Air								2□ No
	the P	Director	Maryland Har:	LOIG	Der	ALL	101 70 0 1							
	A S S	ä					10f. Zip Code	е		10	g. Citizen of \	Whet Cour	ilry?	
	ath a	Funeral	744 High Plain I					.014			U	SA		
	or de	nue	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U,S.	13. V	Vas Decedent of Yes, specify C	of Hispanic Or uben, Mexica	rigin? (Spe in, Puerto F	cify Yas or No- Rican, atc.)		e - Amaric ck, Whita.		
20	be filed within 72 hours after death with the Maryland tial Hygiane. d other than "natural", or items 23a or 28a-f show event, on Marical Example must be notified at		1 Nevar Married 2 Merrie	ed 1 ☐ Yes 2 🔯 N If Yes, Give	lo		☐ Yes 210 N				Specifi	Talle	nite	
Š	ours	d by	3 Widowed 4 Divorced	Yaer or Dates:							Specin	, , , , ,		
Ž	72 h	Completed	15. Decedent' (Specify only highest	s Education greda complated)	166	. Deced	ent's Usuel Occ	cupetion	st of workin	1	6b. Kind of B	usiness/Ind	dustry	
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Maryland 21215-0020	al Harry	Be	17. Fether's Neme (First, Middle, L	ast)	*			18. Moth		(First, Middle, M		na)		
<u>la</u>		10	John Joseph A	nsalvish				Loi	ls Wi	ilma Mo	rton			
an	d 2 should be filed th and Mental Hygis 7 is marked other traumatic event, it	,	19e. Informent's Neme/Reletionsh	Ip (Type, Print)	19	b. Mellin	g Address (Stre	eet and Numb	per or Rure	Route Number,	City or Town,	Steta, Zip	Code)	
	alth 27		Larry O. Ford -	Husband	7	44 H	igh Pla	in Dr.	, Bel	L Air, M	arylan	d 21	L014	
อ	f Healt f Healt ftam 2 other		20e. Method of Disposition		20b. Pieca	of Dispos	sition (Neme of			Dete 2	Oc. Location -	City or To	wn, Stete	
Baltimore,			1 ☐ Burlei 2 ☑ Cremetion				netory or other p			0.07			-	
	it. P		4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funerel Service L		R.A.		is & Co			-3-97	West C	neste	er, Pa	•
g	permit. Pages 1 a Department of Har Important: if item any injury or othe		21. Signatura or Furierer Servica L	Censee		H	Neme end Add	. McCc	omas]	III Fune	ral Ho	me, I	.A.	
										Abingdo		2100		
			23e. Pert1. Enter the disaase, or of shock, or heart feilure. List of	omplications that caused nly one cause on each lin	tha death. Do	not ente	er tha mode of o	tying, such es	s cardiec or	respiratory erre	st,		Approximet intervel Bet	
	Physician						4					ŧ	Onset end I	
	/Medical		Immediate Cause (Finel disaesa or condition	META	Soft	10	Me	ASV	CA	WCER		/	10 YE	ARS
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ŏ		M/u		d										
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j	the sy the	hys	Total algimount condition	a contributing to obatif but	i not resutting	iii liie Gii	derlying causa	Givan in Leit	1.		_/			
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Ö		ete								perform	ed?	ave	elleble prior tomplation of c	to
ā	S S S	gu										of	death?	
	Page 1	Completed								1□ Yes	2 No	1 🗆	Yes 2	No
	Attending Physician: This rideath. ector: After this certificate by the funeral director, pag	Be	25. Wes case referred to medical examiner?					26. Plec	e of Deeth	(Check only one)			
5	nysle	2	1 ☐ Yes 2 1 No	Hospital: 1 Inpatien	nt 2 ER/O	utpatient	3 DOA	Othar: 4 N	ursing Hom	e 5 Pasider	ica 6 🗆 Oth	er (Specif)	y)	
	ding Ph h. Aftar th funeral		27. Menner of Deeth 1 ØNeturel 5 ☐ Pending	28e. Dete of Injury (Month, Day	Year) 28b.	Time of Injury	28c. in	jury at Vork?	2	8d. Describe how	v Injury occur	red		
UNISION	uttendir death. ctor: Al y the fu	atle	2 ☐ Accident investiga	ition	,	,,		☐ Yes 2☐	No					
=	And Br de	ertification:	3 Suicide 6 Could no 4 Homicide determin		ry - At home, fo	erm, stre	et, fectory, offic	a	28	8f. Location (Str. City or Town,		er or Rure	Route Num	ber,
5	a after	Cer	/	building, etc.	(эрвспу)					City of Town,	State)			
	hour hour mere ly fills		29a. Certifier 1 Cartifying	Physician: To the best of	my knowledg	e, deeth	occurred et the	time, dete er	nd plece, er	nd due to tha car	use(s) and me	enner es st	eted.	
	To the Hospital or Atlandi within 24 hours after death To the Funeral Director: A completaly filled in by the t	edical	(Check only 2 Medical Ex	kaminar: On the basis of e end menner stet	examination ar	nd/or inva	astigation, in my	y opinion, dee	eth occurre	d at tha tima, de	te end piece,	and due to	the cause(s)
	Nithir Coth	3	29b. Signature and title of certifier	/	_		29c. Lica	nsa number		29	d. Date signed	d (Month, I	Dey, Year)	1.4
		4	100/7	20/	M	~	12	317-	2	h	Boles	Ms	28 19	791
)			20 20 20 20	Y	/	8	8	111	()	0	72 h	0	1	/
			30. Name and eddress of person w	ho completed cause of de	etn (Item 23e)	(Type, F	rint) 27(2 18	EVA	100	119	2	5	Las
			31 Date filed (Month Day Voor)	((())	اردس،		Mu	5/01	V,	UNINO	LAW	0	207	1
	Sta Registr		31. Dete filed (Month, Day, Year)	1997 32. Joistra	Signature	SIL	R			J				
	Registra	al .	44 m 11 0											



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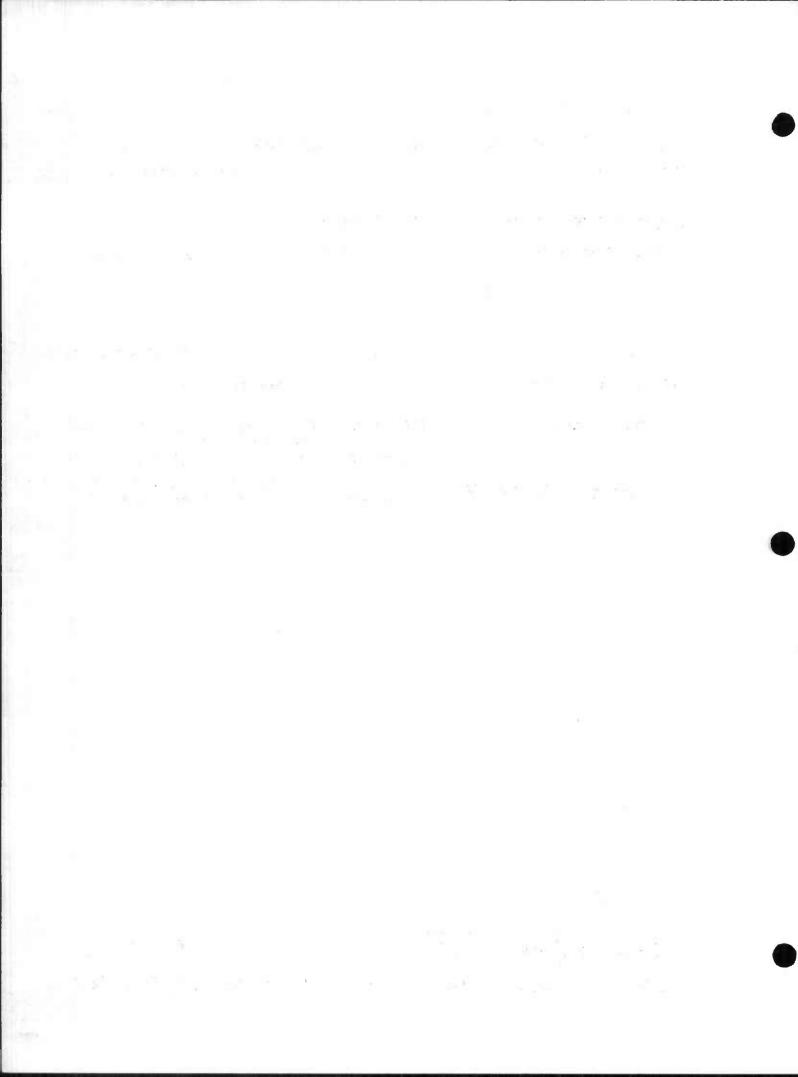
				, , , , , , , , , , , , , , , , , , , ,	Certificate of	Death	Reg. N	9	1 08247
		71	Decedent's Neme (First, Middle, Last)			2.	Deta of Death		3. Time of Death
	Physici /Medic		Oscar C. Fowl	er, Vr.		l N	Month arch 4,	/9 9	
	Examir		4a. Facility Name (If not institution, give street and	number)	4	b. City, Town, or Locat	on of Death 4	c. County of De	eath
			23 Leedom Road B	=1kwood E	states	EIKTON		Ceci	/
I	Funeral Director		5. Sociel Security Number 6. Sax 1⊠ M 2□	7. Aga (In yrs. last bi		If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea ugust 9, 1	9.E	Birthplace (Stata or Foreign Gountry) Jary land
	B .		Usuel Residence of Decedant 10e. Stete 10b. County	10c. City, Tow	um or Location				1011111001110
	aryta asho	7	A .	E IKH	1				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	off the Marylar or 28a-f show be notified at	ecto	10 0 0 10 0 10 10 10 10 10 10 10 10 10 1		100.202		T :		
	£ 52 H	Funeral Director	23 Leedom Road Elki	wood Esta	2/92 2192	1	10g. C	Citizen of What	Country?
	ner dos Nems Der m	ne	11. Meritei Status 12. Was [Arme	Decedant Evar in U,S. 1 Forcas?	13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Specify In, Maxican, Puarto Rice	Yes or No-	14. Rece - Ar Biack, W	marican Indian,
5-0020	6 5	by	1 Navar Married 2 Merried 1 Navar	es 2 No Giva or Detes: WWII	1 ☐ Yes 2 ☒ No				white
5-0	72 houn natural, fical Ex	Completed	15. Decedent's Education (Specify only highast grade complet	16a	. Decedent's Usual Occup (Give kind of work done	ation	16b.	Kind of Busine	ss/Industry
2121	Mar and	nple		e (1-4or 5+)	life. DO NOT use retired)	10.	1	4
	A STATE	Con	8 -		Machi	Nist	10	Januto	acturing
P	and the state of t	Be	17. Fether's Neme (First, Middle, Last)			18. Mother's Name (Fi		,	
yla	Menta Menta arkad atto ev	To Be	Oscar C. Fowlet.			Theres	-		
Maryland	2 sho and and and		19a. Informant's Neme/Reletionship (Type, Print)		b. Mailing Address (Street				
	and mark mark		Floyd Fowler -		P.O. BOX 21			2192	
Baltimore	If the to the output out off		20a. Method of Disposition 1 □ Buriel 2 □ Cremetion 3 □ Ramovai tr	20b. Piece o	of Disposition (Name of ery, crematory or other place	(e)		Location - City	- 4
Ĕ	Pag martin		4 □ Donetion 5 □ Other (Specify)	New Lo	inclose Presbyter	ian Cem. 3/7	197 NE	W LONG	don, PH.
alt	P. P. P. P. P. P. P. P. P. P. P. P. P. P		21. Signature of Europeal Service Licensea		22. Nama and Addres	s of Facility	ee Fus	veral 1	Home
8	88118		1 2 Y Y Y		250 F M	ain St E	What or	1 21	921
			23a. Pert1. Enter the disease or complications the shock, or heart failure. List only one cause	et causad the death. Do					Approximata
	Physician		shock, or heert failure. List only one cause	on aech line.					Intervel Between Onset and Deeth
	/Medical		immediete Ceuse (Finel	- N	0				
	Examiner		disease or condition resulting in deeth) a.	schemic	Cardio mi	opathy			dyrs
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	icate be executed physician and s the burial-transit	Examiner	bC	Due to (or es a	Artery F	ISCOSE			5 413
Ć,	exec in an ial-tr	Ex	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or es a	consequence or).				
68760,	rificate be e ng physiciar as the buri	Cal	that initieted events	Due to for es e	consequenca of):				
68	ifficat ng phy as th	Aedical	resulting in death) Lest	50a 10 (01 a3 a	consequence or,				
Box	ndin	2	d						
-	The law requires that the death cer ate has been signed by the attendir page 2 should be detached for use	Physician/	Dot II Other significant conditions contribution	a double had not consistent to	le the condemnation according	and a Bout	99h Did tahan		
P.O.	the cr	hys	Pert II. Other significant conditions contributing t						ute to the cause of death?
	that hed b	by P	severe correptino	cheumoto	in arthrife	\$	I U Yes	2U NO 3U	Probably 4 Junknown
Records,	uires ngr r ald ble		11			•	24a. Was an aut	opsy 24	b. Were autopsy findings
00	v require been si should t	ete					performed?		available prior to completion of causa of death?
Re	has pe 2	Completed					EL -1957B1		
	: Th icate r, pag						1 🗆 Yas	2 DNG	1 ☐ Yes 2 ☐ No
Division of Vital	ician Sertifi Pecto	Be	25. Wes case reterred to medical examinar?		other all DOA Other	26. Piece of Death (C	heck only one)		
o	this a	2	1 195 2 PM0	☐ Inpatient 2 ☐ ER/O	utpatient 3L DOA	4 D Nursing Homa	-		pecify)
L C	Ing F	lo			Time of 28c. Injury World		Describe how inj	ury occurred	
Sig	tend seath tor: / the t	cat	2 Accident investigation 3 Suicida 6 Could not be			Yes 2 □ No			
<u>≥</u>	or At	Certification:	determined 286. Pl	ace of Injury - At home, to illding, etc. <i>(Specify)</i>	erm, street, factory, office	281.	City or Town, Sta	ind Number or te)	Rural Route Number,
	urs a urs a illed								
	To the Hospital or Attending Physiolen: The is within 24 hours after death. To the Fureral Director: After this certificate ha completely filled in by the funeral director, page.	edical	29e. Certifier (Check only one) 1 Certifying Physician: To 2 Medical Examiner: On the end of the e	e basis of examinetion er	e, deeth occurred et the time nd/or investigation, in my of	ne, date end plece, end pinion, deeth occurred a	due to the cause(it tha time, deta si	s) and manner nd pieca, and c	as stated. due to the cause(s)
	the the	Mec	29b. Signetura end titia of cartifier	nenner stated.	29c. Licanse	number	20d D	ate signed /##	onth, Day, Year)
	8 7 8 7	III	A A		Zou. Cidalise				
	124		Wallsce Oleen	Main In		07129	h	10r 5	1997
	IVA		30. Neme end eddress of person who completed of	· ·			0.0		
	IAII				Ceeiltor	, md	21913		
	Sta			2. Registrer's Signature					
	Registr	ar	MAR 1 1 1997	Ra Davidson B	ndella				



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					,	Certifica	ite of	Death		Reg. No.	97	082	148
r	Physic	ian	1. Decedant's Nama (First, Middla, La	st)					2. Data of D	eath Dey	Year	3. Tin	na of Death
	/Medi	cal	William T.	torbes				4h Oib Taua as	March	10	97	13	PM
	Examir	ner	4e. Fecility Neme (If not institution, giv	1 1.	+ 0 al	1/2	1	4b. City, Town, or	. W.	4c. Co	unty of Deeth		
-	Funeral				(In yrs. last bi		er 1 Yaar		8. Date of B	irth	9. Birth	piaca (St	ata or Foreign
	Director		099 22 6836	X M 2□ €	67	Yrs. Months	s Deys	Hours Min	8. Date of B (Month, D March	3, 193	0 Bro	oklyı	ata or Foraign
	P		Usual Rasidance of Dacedant 10a, State 10b. County		10c. City, Tov	vn or Location						10d Insid	le City Limits
	Maryl f sho	lor	Maryland Prince G	eorge's		t Washid	rton						Yas 2 2006
	r 28a r notil	lrec	10e. Street and Number				ip Code			10g. Citizan	of Whet Cou	untry?	77
	after death with the Maryla or ttems 23s or 23s-f shor miner must be notified at	Funeral Director	11403 Rosalie	Drive			2074	4		United	d Stat	es	
	er dou	nue	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Dec If Yas, sp	edant of hecify Cub	Hispanic Origin? (S an, Maxican, Puar	Specify Yes or N to Rican, atc.)	0- 14.	Rece - Amer Black, White		n,
020	# · · · ·	by F	1 Nevar Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yas XX N If Yas, Giva Year or Datas:	0	1□ Yas	2XXI0	Specify:		Sp	ecify: Wh	ite	
21215-0020	2 hours aturns ical Ex		15. Decedant's Ed	ducation	168	. Decedent's Us	ual Occup	pation	-76	16b. Kind	of Business/I		
21	ithin 7	Completed	(Specify only highest gra Elemantary/Secondary (0-12)	Collega (1-4or 5-	+)		vork dona usa retire	during most of wo	nking				6
	Project Project Tr. III		17 Fether's Name /First Middle 1 and	1	l P	Mailer		40 Manhada Na				Post	Newspă
and	of the f	Be c	17. Fether's Neme (First, Middle, Lest) William Thomas F						ma <i>(First, Middle</i> tte Ford		mama)		
Maryland	shoul nd Ms mark meth	To	19a, Informant's Name/Raiationship (Type, Print)	19	b. Mailing Addre	ss (Street	t and Number or R	•		own, Stete, Z	ip Code)	
ž	alth a 27 is er fres		Kevin M. Forbes					Drive,					
more	ges 1 of He		20e. Mathod of Disposition 1 Burial 2 □ Cremation 3 □	Removel from State	20b. Placa o cemeta	of Disposition (N	ama of rothar pla	March	13,9997		ion - City or 1		
ij,	Pag tant: I fury o		4 □ Donation 5 □ Other (Specif		Resurr	rection		-			ton,Md		
Bal	Depart Import any in		21. Signature of Funaral Sarvice Licar	Day	86	- 22. Nama	end Addre dria	Ferry R	e Funera	al Home	e, Inc 4d 207	6633 35	Old
			23a. Part1 Entar the disassa, or com shock, or haart fellure. List only	plications that caused one cause on each lin	tha daath. Do	not enter tha me	oda of dyl	ng, such as cardia	c or raspiratory	arrest,		Approx	imata Between
	Physician /Medical		Immediata Causa (Final			0			,		i	2/	and Deeth
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	cuted	Examiner	Sequentially list conditions.	b	Due to (or as e	consequence of	^ <i>⊘</i> n):	useas	1			-	1,2
30,	se exectangle		Sequentially list conditions, if any, leading to immediate cause. Entar Undarlying Cause (Disease or Injury that initiated events	Derix	heral	Vaser	ela	n di se	110		1	2-3	415
68760,	the death certificate be executed by the ettending physician and tiched for use as the burial-transit	Medical	that initiated events rasulting in death) Last	C	Due to (or es e	consequence of):						
	5 0 0	√/Me	L	d	-								
. Box	death e etter d for u	Iciai	Part II. Other significant conditions c	ontributing to death but	t not resulting i	in the underlying	i causa di	van in Part I	23h Dic	I tobacco um	contribute	to the car	se of death?
P.0	ires thet the death cer signed by the ettendin d be detached for use	Physician/N	0,	• 4 • •	t not raddining	in the onositying	oudda gi	VOIT II T WITT.		Yee 2 1	~/		4 ☐ Unknown
	es the	by	seeing care	woma									
orc	lew requires thet as been signed b	eted	Chronic obs	Inetive	Au	Runan	e~	diseas	Q 24a. Wa	s an autopsy formed?	8	Vara eutoj valiable p ompletion	
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Vital	iclan: The lav certificate has rector, page 2		25: Was case rafarrad to medical	7 100	100			Of Disco of De		Yas 200	10 1	☐ Yes	2 No
>	5 00	To Be	exeminer? 1 ☐ Yas 2 No	Hospitel: 1 ☐ Inpatier	nt 2 ER/O	utpetient 3 (DOA Oth	har \	ath <i>(Check only</i> Homa 5 ☐ Ras		Other (Spec	ifv)	
n of	ding Phys h. After this funeral di		27. Mannar of Death 1 Natural 5 ☐ Panding	28e. Data of Injury (Month, Dey	y 28b.	Time of Injury	28c. Inju Wo	ry at	28d. Describe	how injury o	ccurred	,,	
Sio	Attending or death. ector: After by the fune	catle	P Accident investigation 3 ☐ Suicide 6 ☐ Could not be		-	M	1 🗆	Yas 2□No					
Division	or Att	Certification:	4 Homicida datermined	28a. Placa of Inju- building, etc.	ry - At homa, fo . <i>(Specify)</i>	erm, straet, fecto	ory, office		28f. Location City or To	(Street and Nown, Stata)	iumber or Ru —	ral Route	Number,
	ppital ours weral filled		29a. Certifier (Certifying Ph	ysician: To the best of	f my knowledge	a death occurre	d et the ti	me deta end plac	e and due to the	causa(s) an	d mannar as	stated	
	To the Heapital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical	(Check only 2 Medical Exam	ninar: On the basis of and mennar stat	axamination ar	nd/or investigetion	on, in my	opinion, deeth occ	urred at the time	, data and pla	ice, and due	to the ceu	se(s)
	To the Com	Σ	29b. Signature and titla of certifiar	AHO	uling	sieum 2	9c. Licens	sa number		29d. Dete s	igned (Month	, Dey, Ye	ar)
			Ysen Hyl	sking, n	W.					03/	10/9	7	
			30. Nama and eddrass of person who	completed causa of da	ath (Itam 23a)	(Type, Print)	14 9	103 B	1 444 11	DA A	111	101	1/
	Sta	te	31. Data filed (Month, Day, Year)	32. Registre	s Signetura		0 4	0	RIANS	KU II	III) L	06	16
	Registr		MAR 1 1 199	17 John d	twoler-	Cardall							

DHMH 16 Rev 6/95



				State of N	raryiand / Depa	rtificate of			gierie 9	7 0	8249
П	Dhoolai		1. Decedent's Neme (First, Middle,	Last)				2. Dete of De		Yeer 3	3. Time of Death
	Physici /Medic		Hazel Finefr			(-		March	,		2:00 AM
	Examir	er	4a. Fecility Neme (If not institution,				4b. City, Town, or L	ocation of Deet	h 4c. County	of Deeth	
١		Ш	Collington Episo				Mitchellv If Under 24 Hrs.			e Georg	
	Funeral Director		5. Sociel Security Number 213-78-1813 Usual Residence of Decedent	6. Sex 7. A 1 ☐ M 2 ☑ F	ge (In yrs. last birthday) 75 Yrs.	Months Deys		8. Dete of Bir (Month, De Feb. 1	y, Year) 2, 1922	9. Birthplece Country) Englan	e (Stete or Foreign ad
	with the Maryland a or 28a-f ahow be notified at	_	10e. Stete 10b. County		10c. City, Town or Lo	ocation					Inside City Limits
	Ne Me	ecto	Maryland Prince	Georges	Bowie	ı					1⊠ Yas 2□No
	vith th	Dire	10e, Street and Number			10f, Zip Code			10g. Citizen of V	Vhat Country?	,
	s 23a	ral	5900 Sutters Co			20715			USA		
Maryland 21215-0020	72 hours after death with the Maryland natural, or items 23s or 28s-f show free Examine must be notified at	by Funeral Director	11. Maritel Stetus 1 Never Merried 2 Marrie 3 Widowed 4 Divorced	12. Wes Deceden Armed Forces od 1 Yes 2 If Yes, Give Yeer or Detes) No	wes Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☒ No	Hispenic Origin? (Spen, Mexican, Puerto Specify:	echy Yes or No Rican, etc.)	Specify	e - American I ck, Whita, etc.	
2-0	72 hours "natural",	ted	15. Decedent's	Education	16a. Dece	dent's Usuel Occup	pation	· In a	16b. Kind of Bu		
21	C 1 6	nple	(Specify only highest Elementery/Secondery (0-12)	College (1-4or	(Give	DO NOT use retire	during most of work d)	ang			
2	Ten 100 to 100	Completed		2	Cler	k			British		sy
pu	tal Hygid d other avant, to	Be	17. Father's Neme (First, Middle, L.	est)			18. Mother's Nem	a (First, Middle	, Meiden Sumem	e)	
yla	12 should be to and Mental I is marked of raumatic avairanted	70	John Douglass M				Gweneth	Garre			
Mai	ges 1 and 2 should be filed to Health and Mental Hyg of 16 Health and Mental Hyg of other traumatic avent,		19e. Informent's Neme/Relationshi				t and Number or Rui				
	1 and Healt am 2		Hugh Massam / B	rother	20b. Plece of Dispo		Agassiz I	British Date	Columbi 20c. Location -		
0 6	nt of it if it		1 ☐ Burial 2 ☑ Cremetion :		cemetery, cre	metory or other ple					
Baltimore,	permit. Pe Departmer Important: any injury		4 ☐ Donetion 5 ☐ Other (Special Signature of Funeral Service ☐		Metropoli	tan Crema 2. Neme end Addre		-1-97	Alexandr	ia, Vi	rginia
Ba	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other trai		Shannon	W. Bam	· Ro	bert E. I	Evans Fund oolis Road				15
			23a. Pert1. Enter the disease, or c shock, or heart feilure. List or	omplications that cause nly one cause on each	ed the eth. Do not en	ter the mode of dyl	ng, such es cardiec	or respiretory e	rrest,	Ap	pproximete lerval Between
	Physician			D	1		ħ			On	nset and Deeth
	/Medicai Examiner		Immediate Cause (Final disease or condition resulting in death)	a les	pizato	4 four	line				gudday
п		-	rooming in doday	MAGI	Due to (or es a consei	quence of):					
112	neit neit	Examiner	AL BOARD IN SU	b. / 0 0 1 C	Whathe,	luy	Concil	wma	,	17	teaus
,	axecu n and lai-tra	Еха	Sequentially list conditions, if any, leeding to immediate	Dona	Due to (or es a consec	Samuel and					10010
68760,	ficate be executed physician and is the burlai-transit	edical	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c.	Due to (or es e consec		roma			1	xave
	.Q C 10		resulting In death) Last		Due to (or es e consec	querice or).					
Box	death certi	300		d							
	deat de att	slots	Pert II. Other significant condition	s contributing to death	but not resulting In the u	nderlying cause gi	ven in Pert I.	23b. Did	tobacco uee co	ntribute to the	e cause of death?
P.0	es that the deeth certifigened by the attending be deteched for use a	by Physician/M	Avenua	of di	nono D	rocar	2	10	Yee 2□ No	3 Probabl	dy 40 Unknown
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B	E as a		05 144					10	/	1 🗆 Ye	es 2 No
of Vital	Physician: this cartific ral director,	o Be	25. Wes case referred to medical examiner?	Hospitel:	ient 2 ER/Outpatler	ot on ou	28. Place of Deal			(C/-)	
o	F F E	n: To	27. Menner of Deeth	28a. Date of In	ury 28b. Time o	f 28c, tnju	ry et		dence 8 Oth		
ion	Attending I r deeth. ector: After by the funer	atio	1 Netural 5 Pending 2 Accident investige		ay Year) Injury	M 1	rk? Yes 2□No				
Division	P P P	Certification:	3 Sulcide 6 Could no determin	and 280. Piece of it	njury - At home, ferm, str stc. (Specify)	reet, factory, office		28f. Location (City or To	Street and Numb wn, Stete)	er or Rural Ro	oute Number,
	Hospital 24 hours Funeral letaly filled	edical	29a. Certifier (Check only one) Certifying	Physician: To the best xaminer: On the basis end manner s	t of my knowledge, deeti of examination and/or in stated.	h occurred et the ti vestigetion, in my o	me, date end plece, opinion, deeth occur	and due to the red et the time,	cause(s) end ma dete and plece,	inner as stated and due to the	d. e cause(s)
	To the within 2 To the comple	Me	29b. Signetyre end title of certifier			29c. Licens	se number		29d. Dete signe	d (Month, Day	/, Year)
			Melin	Alla		D-	37337		030	Lan	
	15)		30. Name and eddress of person w	ho completed cause of	death (Item 23e) (Type,	Print)	11111	511 11	FR .	500	ING
1	1		SK GUDTA	- My OM	0) Grean	in Ane &	= 22-0	Md	200	702	
	Sta Registr	-	31. Dete filed (Month, Day, Year)	7 62. Regis	trer's Signeture						

The state of the s

State of Maryland / Department of Health and Mental Hygiene 08250 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2:02 A.M. FRADET MARCH 04, 1997 HELENE. BERTHE /Medical 4a. Facility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES CAMP SPRINGS MALCOLM GROW MEDICAL CENTER 7. Aga (In yrs. last birthday) If Undar 1 Year If Under 24 Hrs. 8. Data of Birth 10/29/07 9. Birthplace (Stata or Foreign Country)
France 5. Social Sacurity Number **Funeral** Months Daya Hours 1□ M 2/3/F 89 215-19-8531 Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYaa 2□No Directo Maryland Prince George's Ft. Washington 10e. Street and Number 10f, Zip Code 10g. Citizan of What Country? 20744 FRANCE 135 Eagle Head Dr. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas À XNo If Yas, Give Yaar or Dataa: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, apecify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indian, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after a Department of Health and Mental Hygiene. Important: if them 27 le marked other than "natural", or flem any injury or other treumatic event, the Medical Experience and 1 Nevar Married 2 Married 1 ☐ Yes 2 ☐ No Specify: by Specify: ₩Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education 16b. Kind of Business/Industry (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife at home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maldan Sumame) Be Louis Bourdin Louise Arnaud 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Odette Wyatt same as item 10 20b. Placa of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☼ Cremation 3 ☐ Removal from State Metropolitan Crematory 3/4/97 Other (Specify) Alexandria,Va. 4 □ Donation uneral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home Part / Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, no heart failure. List only one cause on each line. Md. 20745 Approximate Intarval Between Onset and Death **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) a. PNEUMONIA Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to complation of causa of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes XX No 1 Yas 2 No 25. Was case raferred to medical Be 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 25 No Impafiant 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Tima of 28d. Dascribe how Injury occurred 5 Pending Investigation 1 Natural 2 Accidant 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 4 Homicide XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signatura and title of certifier 29c. License number 29d. Date algned (Month, Day, Year) MARCH 04, 1997 D45813 30. Name and address of person who ∮omplated cause of death (Item 23a) (Type, Print) 1050 WEST PERIMETER ROAD SUITE C1-7

State Registrar

the Maryland

Baitimore, Maryland 21215-0020

Show

item 27 le marked other than "natural", or items 23a or 28a-f sho other treumstic event, the Medical Examiner must be notified at

physician and the burlat-transit

attending p

the d be detach

peed has page 2

certificate

this funeral

Atter

after death.

Hospital Hours Funeral

To the Hor within 24 h To the Fur

2

Records, P.O. Box 68760. The law requires that the death certificate be

Division of Vital or Attending Physicien: after death.

> 31. Data filed (Month, Day, Year) MAR 04 1997

SCOTT A. WEGNER, MAJ,

32, Registrar'a Signatura Jaki Stwilson Rock ! ANDREWS AIR FORCE BASE MD 20762-6600

USAF, MD

State of Maryland / Department of Health and Mental Hygiene 0,7

08251

						Ce	rtificate	of	Death			Reg. No.	1	00231	
	FIGUR.		1. Decedent's Neme (First, Middle	e, Last)							2. Dete of De	eth	1000	3. Time of Deep	
	Physic		Azalee M. Cond	it Furr							Month	Dey	907	4304	
R.	/Medi Exami		4e. Fecility Name (If not institution	n, <i>give street</i> end nu	ım <i>ber)</i>				4b. City, To	wn, or Lo	ocation of Deeth	4c. Count	• '	7	
11			North Hampton	Manor Nur	sing Ho	me			Frede	ricl	5	Fred	erick		
Н	Funerai		5. Social Security Number	6. Sex	7. Age (fn yrs.				If Under	24 Hrs.	8. Dete of Bir	th		piece (State or Foreig	חל
	Director		579-22-5188	1□M 2∏F	94	Yrs.	Months	Deys	Hours	Min.	May 7,			ntry) Lucky	
	D		Usual Residence of Decedent				1				indy 7,	1703	Rein	cucky	
	year M		10e. Stete 10b. County		10c. Cit	ty, Town or L	ocation							10d. Inside City Limits	5
	a-fa	to	MD Prince	e George'	s Col	mar Ma	nor							1 X Yes 2 No	0
	4 28 P	Director	10e. Street and Number				10f. Zip C	ode				10g. Citizen of	What Cou	intry?	
	urs after death with the Maryland sit, or Items 23s or 23s-f show Examiner must be notified at		3401 43rd Aven	ie			207	22				U.S.A.			
		Funeral	11. Meritei Stetus	12. Wes Dec	edent Ever in U	,S. 13.	Wes Decede	nt of I	Hispenic Orig	gin? (Sp	ecify Yes or No			can indian,	
0	afte min		1 ☐ Never Merried 2 ☐ Merr		2 No		1 ☐ Yes 2			i, r deito	rican, etc./		eck, White,		
20	72 hours after natural", or its dical Examina	1 by	3 ☑ Widowed 4 ☐ Divorced	Yeer or I	Detes:		10 103 22	W 140	эрөспу.			Speci	b: Wh	ite	
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2	than the Me	npf	Elementary/Secondery (0-12)	-	(1-4or 5+)	life.	DO NOT use	retire	ed)						
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3	should nd Mar marks umarks	To	Loyal Pender Be			T .			Ida	Simr	nons				
Maryland 21215-0020	の中華書		19e. informent's Neme/Reletions			19b. Maiii	ng Address (Street	t end Numbe	er or Run	al Route Numbe	er, City or Town	, State, Zi	p Code)	
	and seath m 27		Wilda G. Hamm -	- Daughte					Drive	,_F1	rederic	-			
0	Pages I hent of H mt: If Ne my or of		20e. Method of Disposition 1 ☑ Buriei 2 ☐ Cremetion	3 □Removel from		emetery, cre	osition (Neme metory or oth	er ple	ece)	į	Dete	20c. Location	- City or T	own, Stete	
E	Part Hard		4 ☐ Donetion 5 ☐ Other (S)			rt Lin	coln C	eme	etery	03/	04/97	Brentw	ood,	Maryland	
Baltimore,	permit. Pag Department Important: any injury o	(21. Signature of Funeral Service	vicenses	1-1		2. Neme end				Tune		- a D	A	
Z	88205			LAMA							ons Fune			MD 20781	
	T 20 10		23a. Part1. Enter the diseem or shock, or heart feilure. List	complications that	caused the deat									Approximate Interval Between	
Я	Physician			o, o oadoo o	1									Onset end Deeth	
A	/Medical		tmmediete Cause (Finel diseese or condition	m	ata et	ti	Ru	0	+ 3	200			-	17 days	1
	Examiner		resulting in deeth)	0. / / (.)	Due to (c	or es e conse	quence of):		0 -6-	100			1	1	×
	p .=	Examiner		- Bro	ast Ca	2000							1	17 day	2
	icete be executed physician and s the buriel-transit	E	Sequentielly list conditions,	D. 30		or es e conse	quenca of):							gun	-
0,	e exe	ū	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury										i I		
68760,	hysic the b	edicai	thet initieted events resulting in deeth) Lest	G	Due to (o	r es e consec	quence of):								
9	artific ing p	Me		L ,									!		
Box	The law requires that the death certificete be executed the has been signed by the attending physician and page 2 should be detached for use es the burle-Iransit	an		0						_			1		
	he a	Physician/	Pert ii. Other significant condition	ns contributing to d	leath but not res	ulting in the u	nderlying cau	se gi	iven in Pert i.		23b. Dfd	tobacco use co	ontributs t	to the cause of death	?
P.O.	uires that the dea isigned by the a id be detached f	Æ	Cancatriat	tont F	siline						10	Yes 20 No	3 Pro	bably 4 Unknow	NI
	es the	þ	Congestivet Aontic Ana	reapy 10	ace a								1		
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ec	has b	ğ	. , , , , , , , , , , , , , , , , , , ,	9									of	ompletion of cause death?	
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/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical exeminer?					_	26. Place	of Deet	h (Check only o	ne)			
of	S 00	ို	1 ☐ Yes 2 No	Hospitei: 1 🗆	Inpatient 2	ER/Outpetie	nt 3□ DOA	Otl	her: 4 Nu	rsing Ho	me 5 Resid	dence 6 □Ot	her (Speci	(fy)	
n	Jing Ph h. After th funeral	:uo	27. Menner of Deeth 1 Netural 5 □ Pendin	28a. Dete	of injury hth, Dey Year)	28b. Time o injury	1 280	inju Wo	iry et ork?		28d. Describe I	now injury occu	rred		
0	Attending or death. actor: After by the fune	ati	2 Accident investig	ation			М	1 🗀	Yes 2 1	No					
Division	il or Attending P etter death. Director: After t d in by the funer	Certification:	3 Suicide 6 Could r 4 Homicide determ	ned 286. Pieci	e of Injury - At he	ome, ferm, st	reet, factory,	office			28f. Location (8 City or Tox	Street end Num vn, Stete)	ber or Rur	al Route Number,	
	its or is efter is Dir led in	Ce													
	the Hospital or At hin 24 hours efter of the Funeral Direct repletely filled in by	edicai	29a. Certifier 1 Certifying (Check only 2 Medical I	g Physician: To the Examiner: On the b	best of my kno	wledge, deet	h occurred et	the ti	me, dete end	d piece,	end due to the	cause(s) end m	anner es a	stated.	
	the things the plant	Med	UNB)	end men	ner steted.										
	To the		29b. Signeture end title of certifier	0			_		se number	2		29d. Dete aign			
	(6)			P. Hou				4 ر	460	15		3/11	4.5		
	(0)		30. Neme end eddress of person	who completed cau	se of deeth (Iten	n 23a) (Type,	Print)								
			Mary P. Howel		5 Tollh		venue		Frede	ricl	k , Mar	yland	2170)1	
	Sta		31. Dete filed (Month, Dey, Year)	32. F	Registrer's Signe	ture .	0								
	Registr		MAR	05 1997	Jaliad	Thurston	TANK								
DH	MH 16 Rsv 6/9	5	1414 64 0	_ ,,											

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

7	0	8	2	5	2

Physician /Medical **Examiner**

Director

ρ

1. Decedent's Nama (First, Middla, Last)

MARCH 1,

2. Date of Death

Day 1997 Par

3. Time of Death 352 Pm

10d. Inside City Limits

14 Yas 2 No

Funeral Director

the Maryland death

Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

the burial-transit and attending physician the signed by 8 peen certificate has this funeral After Director: 24 hours a Funeral C pletely

27. Mannar of Death

1 Natural 2 Accident

3 Suicida

29a. Certifier

4 D Homicida

(Check only one)

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" Completed **Physician** /Medical Examiner Examiner Box 68760. Physician/Medical P.O. Division of Vital Records, by Completed Be 2 Certification: i or Attending F Hospital Medical To the

EVELYN Μ. FARMER 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGES DOCTORS COMMUNITY HOSPITAL LANHAM 7. Aga (In yrs. last birthday) 93 Yrs 5. Social Security Number If Undar 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) October 14, 1903 Washington, DC Months Days Min. Hours 1 □ M 2 🗙 F 577-10-6466 Yrs Usual Rasidance of Dacedant 10a State 10c. City, Town or Location Maryland Prince Georges Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 U.S.A. 6009 Magnolia Court 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Never Married 2 Married Specify: White 1 ☐ Yas 2X No Specify: 3X Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Collaga (1-4or 5+) Elementery/Sacondary (0-12) Waitress Reeve's Restaurant 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Grainger James Moriarty 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Panella-Daughter 6009 Magnolia Court, Lanham, MD 20706 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cramation 3 ☐ Ramoval from State 3 Mount Olivet Cemetery Washington, DC 4 □ Donation 5 □ Other (Specify) 22. Nama and Addrass of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham, MD SN the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Immediata Causa (Final diseasa or condition rasulting in deeth) Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disease or Injury that initiated evants rasulting in death) Last Due to (or es e consequence of) Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 25. Was casa referred to medical axaminar? 26. Placa of Death (Check only ona) Hospitat: 1 Inpatient 2 ER/Outpatlent 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No

29b. Signatura and titla of certifiar Cercity

5 Pending invastigation

6 Could not be datarmined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D 16273

Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 Yes 2 No

29d. Data signed (Month, Day, Year)

28f. Location (Streat and Number or Rural Routa Number, City or Town, Steta)

REVATING MURTHS, 6130 LANDOUER Rd, LANDOUER

28a. Data of Injury (Month, Dey Year)

28d. Describe how injury occurred

NO 20785

1 ☐ Yes 2 ☐ No

State Registrar

31. Dsta filed (Month, Day, Year) MAR 06 1997

28b. Time of Injury

28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

There is a few and the

			Certificate of		Reg. No.	08253	
Physician /Medical	1. Decedent's Neme (First, Middla, Les Helen	Gamble		2. Dete of Month Marc	ch 3, 199		
Examiner Funeral Director	4a. Facility Nama (ff not institution, give Holy Cross Hols Social Security Number 6. St. 104-42-8074	spital		4b. City, Town, or Location of Do Silver Sprin If Undar 24 Hrs. 8. Dete of Month, Apr.	MONTGO		
of show fied at	Usual Residence of Decedent 10a. State		wn or Location ilver Spri			10d. inside City Limits 1 ☐ Yas 2 ☒No	
tiems 23s or 28s-f sho liner must be notified at Tuneral Director	10e. Street and Number 2717 Terrapin		906	U.S.A.	ountry?		
Exam	11. Marital Status 1 □ Nevar Married 2 Merried 3 □ Widowed 4 □ Divorced	12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2₹ No tf Yes, Give Yaar or Dates:	13. Wes Decedent of I If Yas, specify Cub	Hispanic Origin? (Specify Yas or an, Mexican, Puerto Rican, etc.) Specify:	No- 14. Race - Ami Bleck, Whi Specify: B1	te, etc.	
ygiene, ner then "neturn nt, the Medical. Completed	15. Decedent's Ed (Spacify only highest grad Elementary/Secondery (0-12)	GOIIROR (1-40f 5+)	a. Decedent's Usuel Occup (Give kind of work done tife. DO NOT use retire Procuremen		16b. Kind of Business U.S. GOV		
Be see	17. Fethar's Nema (First, Middle, Last) Lester P. Adaw	ay, Sr.		18. Mother's Neme (First, Mid Helen Le			
m 2	19e. Informent's Neme/Reletionship (7 Alvin K. Gambl 20e. Method of Disposition	e (Husband) 2	_	in Rd., Silv		MD 20906	
important: If them 27 if any Injury or other tra phose.	MDBurial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify 2) Soniture of Funeral Service Licent	Removal from State Ash	ery, cremetory or other ple Memorial C 22. Neme end Addre	em. 3/8/97			
nding physician and with the burdal-fransit and last the b	23a. Part I. Enter the disease, or companies to the shock, or heart feature. List only of immediate Cause (Final disease or condition resulting in daeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initisted events resulting in deeth) Lsst	e. SEPSIS Due to (or ss. p. MALIGNA) Due to (or es. p. METASTAT Due to (or as a d	s consequence of): consequence of): consequence of): consequence of):	EURAL EFT	y arrast,		
should be d		milesting to established for for fooding	in the arternying datase gr	248. W	□ Y88 2 No 3 P	Probably 4 Unknown Were sutopsy findings available prior to completion of causa of death?	
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ector: After this by the funeral di iffication: To	axaminer? 1 Yas 2 No 27. Menner of Death 1 Neturei 5 Pending investigetion 3 Suicide 6 Could not be determined	(Month, Day Year) 28e. Piece of injury - At home,	Time of injury M 1	ry et rk? 28d. Descri	Rasidence 6 Othar (Specify) write how injury occurred ion (Street and Number or Rural Route Number,		
within 24 hours after deat To the Funeral Director: completely filled in by the Medical Certifica	29e. Certifier 1 ☐ Certifying Phy (Check only 2 ☐ Medical Exam	building, etc. (Specify) slcisn: To the best of my knowled; iner: On the basis of examination e	ge, death occurred at the ti nd/or investigation, in my o	me, date and pieca, end due to t	Town, State) the ceuse(s) end menner ane, dete and plece, and du	s steted. a to the cause(s)	
To the comple	285. Signeture end title of certifier	and menner steted.	M.D 29c. Licans		29d. Data signed (Mon		
/	30 Name and eddress of person who o	ompleted cause of death from 23	(Type, Print)	5 SILVER	T00 -	110 0-01	

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

	an	1. Decedant's Na	ma (First, Middla, L						2. Date of D	Reg. No. eath	Yaar	3. Time of Dea
/Medi		Car	melaD	, Gaeta					Mar	ch 3	1997	8:06 F
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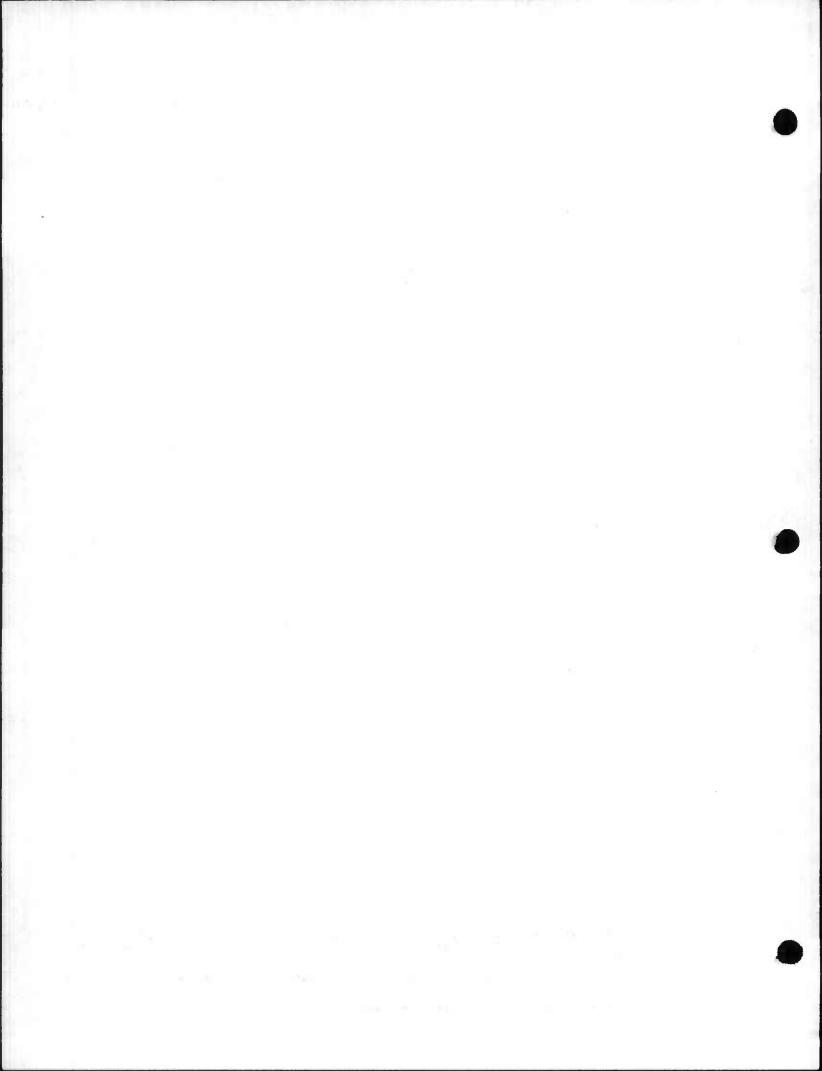
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	Decedent's Name (First, Middle, Last)		ertificate of			Reg. No.	97 08	B255
п	Physic		Mary B. Gibson				Month March	1, 199	Year	8:00 AM
b	/Medi Exami		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or	Location of Deat			O.OO Ann
1	LAGIIII	ICI	10705 Jamaica Dr.			Silver	Spring		gomery	
Н	Funeral			(In yrs. last birthda	if Undar 1 Yaar	If Undar 24 Hr			9. Birthplace (Si Country)	tate or Foraign
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	Aaryland I show	٥		10c. City, Town or		NTC.				da City Limits Yes 2□No
	10 the 10	Director	MD . MONTGOMERY 10e. Street and Number	SIT	VER SPRI	NG		10g. Citizan of V	- 41	
	with w					0902			J.S.A.	
	Pa 20	era	10705 JAMAICA DR.	ver in U.S. 1			Specify Yes or No		- American india	n .
020	72 hours after death with the Maryland natural; or items 23a or 28a-f show after Examiner must be notified at	by Funeral	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No. 1 Yes, Give 3 Widowed 4 Divorced Year or Datas:		3. Was Decedent of In If Yes, specify Cub. 1 ☐ Yes 2 ☑ No	an, Mexicen, Pue Specify:	rto Ricen, etc.)	Blac Specify	k, White, etc.	
ŏ	"natural",		15. Decedent's Education	16a. De	cedent's Usual Occup	pation		16b. Kind of Bu		
21215-0020	9	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	(Gi	ve kind of work done DO NOT use retire	during most of wo d)	orking			
7	yien The	E O	5+	,	HOMEMA!	KER		AT	HOME	
b	be filed tal Hygid d other event, II	Be	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle	Maiden Sumam	e)	
Maryland		To	WALTER G. H	BULLARD		GF	RACE	V. E	EVER	
an	d 2 should th and Mer 7 is marks traumatic		19a. Informant's Name/Relationship (Type, Print)	19b. Ma	ailing Address (Street	and Number or F	lural Route Numb	er, City or Town,	State, Zip Code)	
			HAROLD F. GIBSON/HUSE	BAND	SAME AS	ITEM	#10			
ore	of poly		20a. Method of Disposition 1 □ Burlal 2 ▼ Cremation 3 □ Ramoval from State	20b. Place of Dis	position (Name of rematory or other place	ce)	Date	20c. Location -	City or Town, Sta	te
E	Pa Int:		4 Donation 5 Other (Specify)	CHAMBI	ERS CREM	ATORY	3/4	RIVE	RDALE,	MD.
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Servica Licen	200001	22. Name and Addra				ING, M	
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U	Physician		shock, or heart failure. List only one cause on each line				,	,	Interva	l Between and Death
1	/Medical		Immediate Cause (Final		1.				11	
	Examiner		disease or condition resulting in death) a.	ue to (or as a cons	neces				1/200	4
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	be executed sician and burial-transit	Examiner	Sequentially list conditions b. D	ue to (or as a cons	sequence of):	alens				
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68760,	ificate be executed g physician and as the buriai-transit	edicai	Cause (Disease or Injury that Initiated events resulting in death) Last	to (or as a cons	equence of):	wy			1	
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	ng Ph fter thi		27. Manner of Death 1 Natural 5 Pending (Month, Day)	Year) 28b. Time		y at k?	28d. Describe	now injury occurr	ed	
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≥	or Att	E E	3 Suicide 6 Could not be determined 28e. Piace of Injury building, etc.	y - At home, farm, : (Specify)	street, factory, office		28f. Location (Street and Numbern, State)	er or Aural Aoute	Number,
2	urs al									
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	29a. Certifier (Check only one) (Securifying Physician: To the best of and mannar state	xamination and/or	ath occurred at the tir investigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and ma date and place, e	nner as stated. Ind due to the ceu	use(s)
		Σ	29b. Signature and title of certifiar		29c. Licans	a number		1 1	(Month, Day, Ye	ar)
	10		I fruit ///		Do	1792		3/3/9	7	
,	,		30. Name and address of person who completed cause of dea	th (Item 23a) (Typ						
			IRNEST S. OSER, M.D.	10301	GEORGIA	AVE.#3	304, SI	LVER SE	RING, M	D.2090
	Sta	te	31. Date filed (Month, Day, Year) Registrar							
	Registr	ar	MAR 0 4 1997 Jan	door-Binde	02					

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 08256 Certificate of Death 1. Decedant's Nama (First, Middia, Last) 2. Data of Death 3. Tima of Death **Physician** 9:55 Aug Francis Joseph Ging /Medical 4a. Facility Nama (If not Institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3-F Eastway Road **Greenbelt** Prince George's If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foraign Country) **Funeral** 78 Yrs. XXM 2 F 160-16-1909 Director Dec. 27, 1918 Pennsylvania Usual Residance of Dacadant the Marylend 10b. County 10c. City. Town or Location or 28a-f show 10d. Insida City Limits the Medical Examiner must be notified at Maryland Prince George's Greenbelt 1XX as 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 3-F Eastway Road 20770 United States 238 death Funeral 12. Was Decedant Evar in U,S. Armed Forcas? AZYas 2 ☐ No 'natural', or items 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxicen, Puarto Rican, atc.) Raca - Amarlcan Indian, Black, Whita, atc. filed within 72 hours efter 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas ZONo Specify: White by 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: WWII Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decadent's Education (Spacify only highast grada complated) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Postal Supervisor U.S. Postal Service other 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meidan Sumama) Be permit. Pages 1 and 2 should be fi Department of Health and Mental H Important: If Nem 27 is marked oft any injury or other traumatic ever any injury or other traumatic ever Pages 1 and 2 should be nent of Health and Mental Francis Joseph Ging Kathryn Dougherty 10 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rurel Routa Numbar, City or Town, Steta, Zip Coda) Mary E. Ging (wife) sameas #10 20b. Placa of Disposition (Nema of cematary, crematory or other) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Gate of Heaven Cemetery 3/3/1997 Silver Spring, Maryland XX Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Dogation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Road Beltsville, Maryland20705 23a. Part : Entar the disease, or complications that ceused the death. Do not entar the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Intarval Between Onsat and Death **Physician** /Medicai Immadiate Causa (Final almonary Cantler 4 mos disaasa or condition rasulting in death) Examiner Physician/Medical Examiner sician and buriel-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadieta causa. Entar Underlying Causa (Diseasa or injury that initiated evants rasuiting in death) Last Due to (or as a consequence of): P.O. Box 68760, the Dua to (or as a consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown rescular auchent Records, þ page 2 should be abdominal unerysu 24b. Ware autopsy tindings availabla prior to complation of ceusa of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☑ No certificate Division of Vital or Attending Physicien: director. Be 25. Was casa raterred to medical axaminar? 26. Piace of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 2 his lilled in by the funeral 27. Manner of Deeth Certification: 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred After 1 Netural 5 Panding after death. 1 Yas 2 No 2 Accidant Invastigation 6 Could not be datarmined 28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Spacify) 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 - Homicida To the Hospital within 24 hours a To the Funeral D 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, dete end piace, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated. Medical 29a. Certifier (Check only one) 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) autioup 7572 30. Nema and addrass of person who complated cause of deeth (Item 23a) (Type, Print) 2. gran, teva 115 Center way greenfelt, VID 20270 31. Date tiled (Month, Day, Year) 32. Registrer's Signatura State MAR 0 4 1997 Registrar

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time at Death February 26, 1997 **Physician** Margaret Lewis Goad 5:30A. /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 11713 Ash Road Beltsville Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 8, 1932 9. Birthpiace (State or Foreign **Funeral** 10 M 200 Months Days Hours Min 220-28-6344 64 Yrs. Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location Beltsville a how 10d. Inside City Limits r than "natural", or items 23a or 25a-f show the Medical Examiner must be notified at Maryland Prince George's Director 1 Yes XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 11713 Ash Road 20705 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22. No If Yes, Give Yeer or Dates: 11. Maritei Status Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Biack, White, etc. 72 hours after 1 Never Married 2 X Married 1□ Yes 2♥No White Baltimore, Maryland 21215-0020 þ Specify 3 ☐ Widowed 4 ☐ Divorcad Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) Hygiana. United States Elementary/Secondary (0-12) Coilege (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If them 27 is marked other the any Injury or other traumatic event the Postal Clerk Postal Service 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be John H. Lewis Esther Lugo 19e. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Bruce Goad (Husband) sameas #10 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X uriai 2 ☐ Cremetion 3 ☐ Removei from State St. John's Episcopal Church Cemetery 3/1/1997 Beltsville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 21. Sig 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset end Deeth Physician /Medical immediate Cause (Final disease or condition resulting in death) Examiner tastatic physician and s the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 The law requires that the death certificate be Physician/Medical Due to (or as a consequenca of) 88 esn ò P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? the 1 Yes 2 No 3 Probably 4 Unknown Records, by Completed 24b. Were autopsy findings 24a. Was an autopsy performed? available prior to completion of cause of death? has page 2 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 1Vo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Dey Year) Certification: 27. Menner of Death 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death.

Funeral Director: After to beletely filled in by the funeral After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, dete and piaca, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi Medicai (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Neme and address of persign Iw, Washingto al. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Culia Davidson

MAR 04

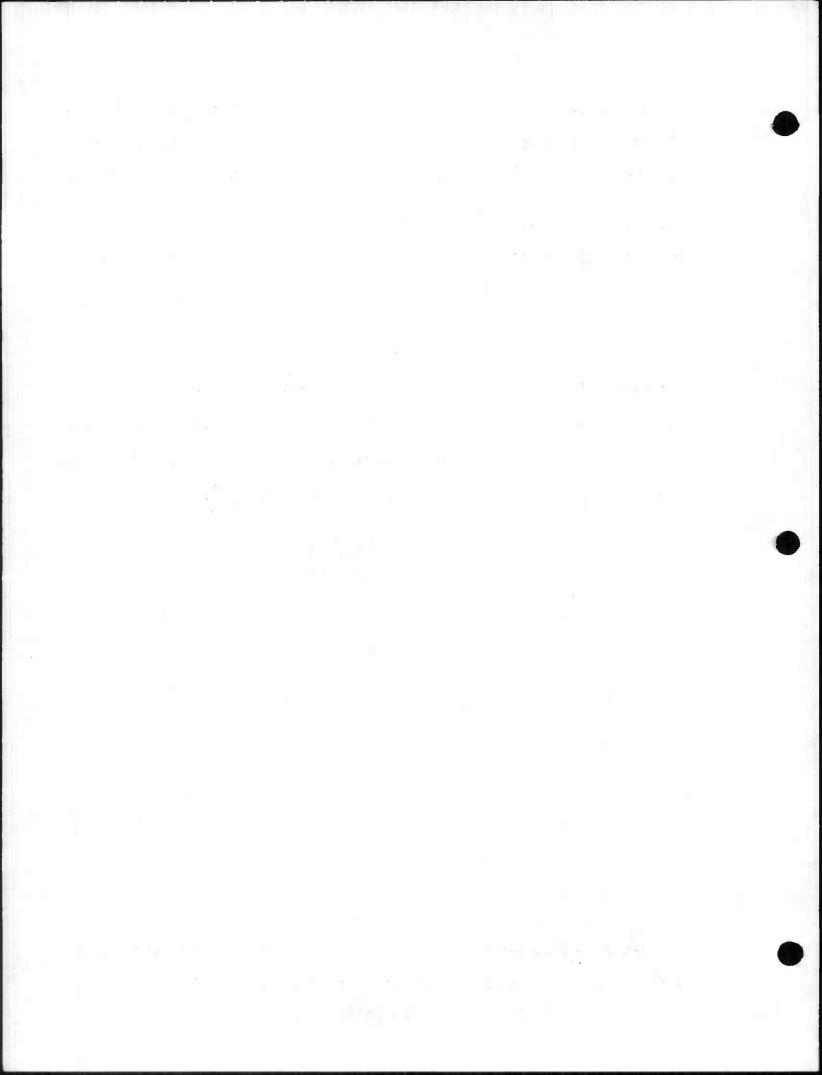
DHMH 16 Rev 6/95

Registrar

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					Cer	tificate of	Death		Reg. N	lo. 9	7 08258
Physic	ian	1. Decedent's Name (First, Middle, I	ast)					2. Date of I		ay Y	3. Time of Death
/Medi		Lila Grace Gree	n					Febru	ary i	28, 19	
Exami		4a. Facility Nama (If not institution, g						n, or Location of Da	ath 4	c. County of	Death
		Manor Care Ferr					Bethes			Montgo	
Funeral Director		318-10-2428	Sax 1□M 2X F	a (In yrs. last bi	rthday) Yrs.	Months Days		Min. 8. Date of the Month, August	Birth Day, Yea 15,]	908	Birthplace (State or Foreig Country)
P R		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	vn or Loc	ation					10d. Insida City Limits
in the Marylar or 28a-f show re notified at	ō	Maryland Montgon	10 8 1	Rockvi							1 □XYes 2 □ No
De 1	Directo	10e. Street and Number	iery	NUCKVI	TIE	10f. Zip Code	_		100.0	itizen of Wh	
death with the Maryland rns 23a or 28a-f show crives be notified at		124 South VanBure	n Street			20850				ited S	
nemit. Pages 1 and 2 should be filed within 72 hours after de "Apparament of Health and Memail Hygieno." natural", or itams important: if them 27 is marked other than "natural", or itams my fillury or other traumatic event, the Medical Examiner in this.	1 Nevar Merriad 2 Married 1 Yes 2 No					/as Decedent of Yes, specify Cut ☐ Yes 2☐XNo		n? (Specify Yas or I Puerto Rican, etc.)	No-		American Indian, White, etc. White
72 ho natur	ted	15. Decedent's		16a	. Deced	ant's Usual Occu	pation	A. Salata	16b.	Kind of Busin	nass/industry
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Hand Hand		17. Father's Nama (First, Middle, Las	et)		ACC	countant	18 Mother's	s Name (First, Mido	-	wholes	are
ed be de de de de de de de de de de de de de	Be	Richard A. Levi								in ournaine)	
d Me d Me mark	2	19a. Informant's Name/Relationship		10	Mallin	Addrona /Stran		or Rural Route Num		as Taura Ch	at 75 Octo
14 B B B B B B B B B B B B B B B B B B B		Richard J. Green	(Typa, Finn)								
6 1 an (Heal bern 2 other		20a. Method of Disposition				ition (Name of atory or other pla		Street, R	T		MD 20850 by or Town, State
Pages sent of int: If the iry or o		1 ☐ Burial 2 ☐ Cremation 3									
Semit. Pag Separtment mportant: iny injury c those.		4 Donation 5 Other (Spec		Chesa		e Crema		3-1-97	Be	ltsvil	le, Maryland
permit. Pag Department Important: any injury o		21. Signature of Funeral Service Lice	a Del		Ra 93	Name and Addr pp Fune	ess of Facility ral Ser Avenue	rvices, P Silver	.A. Spri	na MD	20910
		23a. Part1. Entar the disease, or conshock, or heart tailure. List only	nplications that caused	tha daath. Do	not ente	r tha moda of dy	ing, such as ce	ordiac or raspiratory	errest,	19, 110	Approximate Interval Between
Physician	1	arrang of front failure. End of fi	, one dance of each in								Onsat and Death
/Medical		Immediate Cause (Final diseasa or condition	Pneumon	nia							days
Examiner		resulting in daath)	a	Dua to (or as a	consequ	uence of):					days
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death certificate be executed e attending physician and of for use as the buriel-transit	Examiner	Sequentially list conditions,	D	Due to (or as a	consequ	ienca of):					
ifficete be exa g physiclan as the buriel		Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disaasa or Injury	C								
sete chysi	Medicai	thet initiated events resulting in death) Last		Due to (or as a	consequ	enca of):					
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e de the s	/sic	Part II. Other eignificent conditions	contributing to death bu	ut not resulting i	n tha und	darlying cause gi	van in Part f.	23b. Di	d tobacc	o uee contri	bute to the cause of death
thet the de ed by the a detached	Ph	Dementia						1[□ Yee	2□ No 3	☐ Probably 4 🕅 Unknow
S 20	þ	Demetrora									
requ	Completed		*1						as an auto rformed?	opsy 2	24b. Were autopsy findings evailable prior to completion of ceusa of daath?
The law ate has b pege 2 s	E O							10	Yes :	ZYNO	1 ☐ Yes 2 ☐ No
		25. Was case referred to medical					OC Disco o			2 1.3(140	TEL 165 ZEM40
	o Be	exeminer?	Hospital:	• • □ □ □ □ □ □ □		on not		Death (Check only		a 🗆 🗆	(0(1)
Phys ratio	1: To	27. Mannar of Death	1 Inpatier		Tima of	3LI DON	4 LA NUIS	ing Home 5 Re			(Specify)
ding I After funer	to	1 Netural 5 ☐ Panding	28a. Data of Injury (Month, Day	Year)	Injury	28c. inju	irk?]Yes 2∐No		,,,,,	.,	
Attending ir deeth. Deter: Affei by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not	De Dise of lain	Inv - At home fa	rm stra		, , , , ,		(Street s	and Number	or Rural Route Number,
or A effer Direction	erti	4 Homicida determina	building, etc.	. (Specify)	iriii, stiai	er, ractory, office		City or T	own, Sta	te)	or rigidir route riginizer,
To the Hospital or Attending Phyminic 24 hours effer deeth. To the Funeral Director: After this completely filled in by the funeral	edicai C	Check only 2 Medical Exa	hysician: To the best of minar: On the basis of	f my knowledge examination an	e, death	occurred at the ti	ma, data and popinion, death	place, and due to the	e cause(s) and menn	ar as stated.
the the	Med	one,	and manner stat	ted.							
or we co		29b. Signature and titla of pertifier	100	14	40	29c. Lican					Month, Day, Year)
		fre of	helm	//	U	D205	18		Feb	ruary	28, 1997
5		30. Name and address of person who					_ 02				
3		Joel Schulman, M					, Bethe	esda, MD	208	54	
Sta	te	31. Date filed (Month, Day, Year)	32. Registra	signature		40 • • •					
Registr	ar	MAR 0	3 199/	tima Davi	dson-	gandese					



Certificate of Death

12:17PM

10d. Insida City Limits

WHITE

Approximeta Intarval Batwaan Onset and Death

29d. Date signed (Month, Dey, Year)

72 45.

1 ☐ Yes 2 X No

1. Decedant's Nama (First, Middla, Last)

10

Medical

State Registrar 29a. Certifia: (Check only one)

29b. Signature and title of certific

the Hospital

Box 68760.

P.O.

Records,

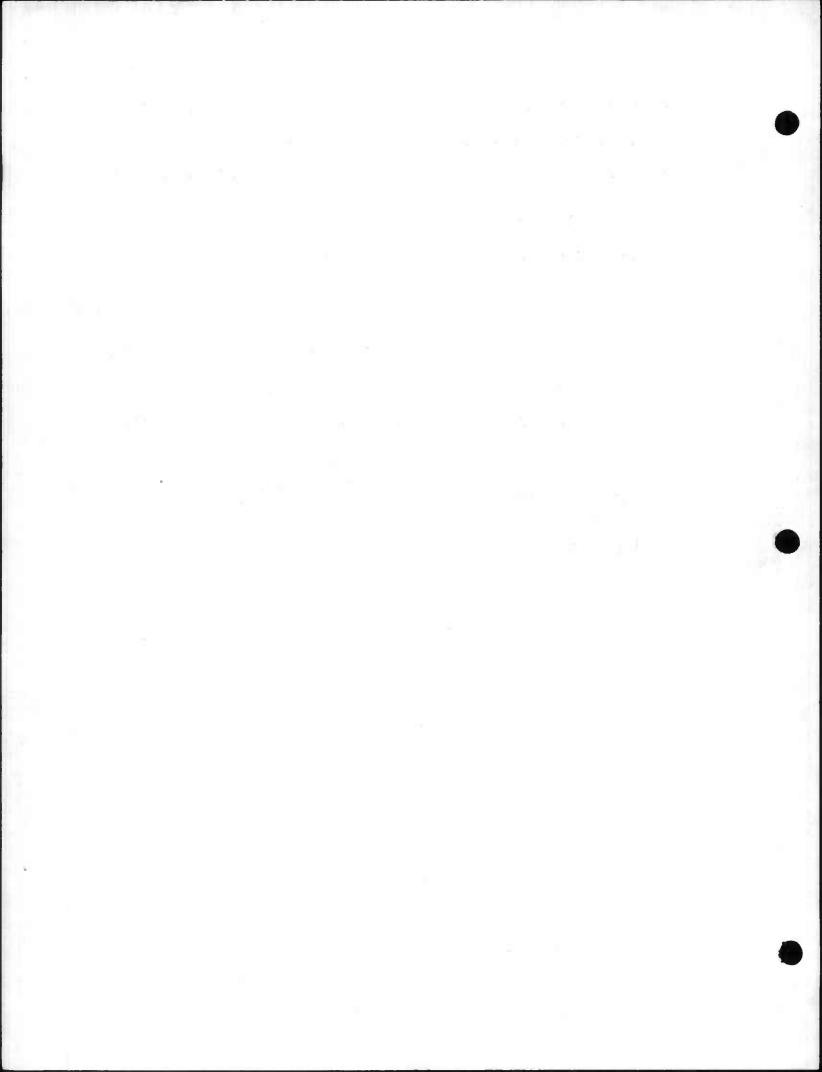
Division of Vital

30. Nama and address of parson who completed cause of daath (Item 23a) (Type, Print)

18/11 | PRINCE PHILLEP BR. OL Ling MARYLAND ZO83 Z 32. Registrary Signature
7 Julia Davidson-Randolle 31. Data filed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.
2 Medical Examinar: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the causa(s) and manner stated.

29c. License number



				State of N	Maryland .		tment of I ificate of		nd Mental I	Hygiene Reg. No.	97	08260
	Physic /Medi		Decedant's Nama (First, Middle, I HELEN	GUSTAS					2. Date of Month MARCI	Day 199	Yaar 7	3. Tima of Death 8:30 PM
7	Exami	ner	4a. Facility Nama (If not institution, g Springbrook Adve Renabilitatio						n, or Location of D Spring		nty of Death	***
	Funeral Director		5. Social Security Number 6. 174-03-3903		Aga (In yrs. last		If Undar 1 Year Months Days	If Undar 2	Hrs. 8. Data of (Month)	Birth Day, Year)	9. Birthp Coun	lace (Stata or Foreign try)
	show dat		Usual Rasidance of Decedant 10a. State 10b. County		10c. City, T	own or Loca	tion				1	0d. Insida City Limits
	the Mar 28e-f st notified	Director	Maryland Montg	omery	Si	lver S	pring 10f. Zip Coda			10g. Chizan	-4 M/h - 1 Co	1 ☐ Yas 2 ☒ No
	3a or		13001 Blue Valle	v D1200			Tor. Zip Coda	20904		U.S		try r
20	a after death , or items 2 aminer mu	by Funeral	11. Marital Status 1⊠ Nevar Married 2 Married	12. Was Deceder Armed Forces 1 ☐ Yes 25 If Yas, Giva	s? ₫ No		s Decedent of I	Hispanic Origi an, Mexicen,	n? (Specity Yea or Puarto Ricen, atc.)		Race - Amaric Black, Whita,	
8	2 hours shurs/ cal Ex	q pe	3 ☐ Widowed 4 ☐ Divorced 15. Decedant'a	Yaar or Datas Education		6a. Decedar	nt's Usuai Occu	pation				ite
Maryland 21215-0020	vithin 72 rie. han "nat e Medica	Completed	(Specify only highast g Eiementary/Secondary (0-12)	rade completed) Collage (1-40		(Give kir lifa. DC	d of work dona NOT use retire	during most (of working			,,
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/lan	Aental Aental rhad o	To Be	Michael Gust	ashaw					Mary R	Sahol		
Aan	2 sho and h is ma sums		19a. tnformant'a Name/Relationship	(Type, Print)	1	19b. Malling	Addrass (Street	and Number	or Rural Routa Nu	mber, City or To	vn, Stata, Zip	Code) 20904
Baltimore, A	iges 1 and it of Health if Nem 27 or other tr		John S. Vamos 20e. Mathod of Disposition 1 Buriai 2 Coremation 3		20b. Place	3001 B	lue Val	ley Pl	ace Sil	ver Spri	ng, Mar on - City or To	yland
튶	artmer artmer ortant injury		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		Metr		an Cres		3/04/9	7 Alexar	idria,	Virginia
å	Deg page		mul 6	201		Fra	ncis J.	Colli	ns Funer			
	Physician /Medical		23a. Part1. Enter the disease, or co- ahock, or heart failure. List onl			Do nof enter	Univer the moda of dyi	ng, auch as c	1vd., W., ardiac or respirator	SILVET S ry arrest,	pring,	Approximate Interval Between Onset and Death
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	pe #	nlner		b. Poo	- No	4-1+1	onal	Sta	tus			3 y-s.
Ć	be executed siclan end burial-transit	Examiner	Saquantially list conditions, if any, leading to immadiate cause. Enfer Undarlying Causa (Disease or Injury	San	Dyla to (or as	a conseque	nce of):/	, o for	Alzhe		2/2	1345
Box 68760,	the the	edical	Causa (Disease or Injury that initiated evants rasulting in death) Lasf	c	Due to (or as	a consequa		2 10	111676	, mes	25	
	the atte	sicia	Part II. Other eignificant conditions	contributing to death	buf not rasultin	g in the und	artying sauaa gi	van in Part I.	23b, I	Old tobacco use	contribute to	the cause of death?
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Records,	aw requir	Completed by Physician/M	Mild Gluc	ose In	tole-	unc e	-		24a. V	Vas an autopsy erformed?	cor	ara autopsy findings allable prior to mplation of cause death?
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n of	g Physics ter this neral d	n: T	27. Manner of Death	28a. Date of the		b. Tima of Injury	28c. Inju			be how injury occ		()
Division	or Attending after death. Director: After in by the fune	Certification:	1 Natural 5 Pending 2 Accidant invastigati 3 Suicida 6 Couid not datarmine	be 28a. Place of I			M 1□	Yas 2□N	28f. Locatio	on (Street and Nu Town, Stata)	m <i>ber</i> o <i>r Rura</i>	l Routa Number,
٥	Hospital A hours Funeral tely filled	edicai Ce	29a. Certifiar 1 ✓ Certifying P (Check only one) 2 ☐ Medical Exe	Physician: To the bes	of axamination	dge, death o	ocurred et tha ti	ma, dete and opinion, daath	place, end due to occurred at tha tir	tha causa(s) and na, data and plec	manner as at	eted. tha cause(s)
	within 2 To the	Mec	29b. Signature and time of postuling	and mannar a	ndieu.		29c. Licens	se number		29d. Date sig	ged (Month,	Day, Year)
	->-0		eft &	KT			D3	100	0/	31	4/97	
	.1		30. Nama and address of person who	completed chase of	death (I)em 23	a) (Type, Pri	1	•	reenvr	ay Cut.	. Dr.	#430
	4		Stourt J. 31. Data filed (Month, Day, Year)	1 urken	trans Signatura	M.D.	6.6	enbe	It, Md.	20%	170.	
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** :00 dm March 1997 /Medical 6 4a. Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6545 Carlinda Avenue Columbia Howard If Under 1 Hunder 24 Hrs. Hours Min. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2⊠F Yrs. Director 216-32-9663 63 Mar 28, 1933 Maryland Usual Rasidence of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Tyas 2 TXNo Director Maryland Howard Columbia 10f. Zip Coda 10e. Street and Number 10g. Citizen of What Country? 6545 Carlinda Avenue 21046 United States Funeral 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas 220 No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 ☑ No Specify: Specify: à 3√2 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 12 Clerical Utility Company 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Albert Brauer Anne Salkins 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Allen Peddicord/Executor 4001 High Point Road Ellicott City, MD 21042 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 3-10-97 Baltimore, Maryland Moreland Memorial Park 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Harry H. Witzke Funeral Home, Inc. llino 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) Examiner Sequantially list conditions, if any, leading to immadiata ceusa. Entar Undarlying Cause (Disease or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): Physician/Medicai Dua to (or as a consaquence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Wara autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of causa of death? 1 Yas 2 No 1 Yas 2 No 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Other: 4 Nursing Horna 5 Rasidanca 6 Other (Specify) 10 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Death 26a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 5 Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Could not be datarminad Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 D Homicida Medical 29a. Certifian 1🗹 Certifying Phyaician: To tha best of my knowledge, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature aptititle of certifi 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Name and impleted glusa of death (Itam 23a) (Type, Pr Moryland 21042 Chery Dungan Burk 480 D/seu 33 Registrar's Signatura

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"natural", or itsms 23a

filed within 72 hours after Hygiene. Oher than "natural", or its

Pages 1 and 2 should be illed viert of Health and Mental Hygis ret. If item 27 is marked other

important: If then 27 is m any injury or other

physician and the burial-transit

attending for use as

the á

signed b

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certificate has page 2

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

within 24 hours after To the Funeral Dire completely filled in b

Maryland 21215-0020

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

The law requires that the death certificate be

4

notifie

State Registrar 31. Data filed (Month, Day, Year)

0 7 1997

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** MILDRED EVANS /Medical 4a. Fecility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital of Cecil County E1kton Cecil If Under 1 Yaer if Undar 24 Hrs. 8. Data of Birth (Month, Dey, Year) 5. Sociei Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplaca (State or Foreign Country) **Funeral** Months 1 □ M 2 🗓 F Yrs. **Director** 201-10-6840 Oct. 8, 1919 Pennsylvania Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryta Cecil Charlestown 1X Yes 2 No Director Maryland 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? rvs 23a or 7 21914 215 Louisa Lane U.S.A. Funeral death than "natural", or items the Medical Examiner m 12. Was Decedant Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11. Meritel Stetus 14. Race - American Indien, Bieck, Whita, atc. Pages 1 and 2 should be filed within 72 hours after nant of Health and Mantal Hygiene.

Int. If Hem 27 is marked other than "natural", or he 1 ☐ Yes 2 XNo If Yes, Give 1 Never Merried 2 Married Maryland 21215-0020 Specify: White 1 ☐ Yes 2 No Specify: þ 3X Widowed 4 ☐ Divorcad Yaer or Detes: Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Construction and Elementery/Secondery (0-12) College (1-4or 5+) Railroad 1 Administrative Assistant 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) James Windolph Turner Edna Asher Bur 2 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 612 Creek Lane - Flourtown, PA 19031 John J. Gray - Son Baltimore, 20b. Plece of Disposition (Name of cemetary, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Buriel 2 🖾 Cremetion 3 ☐ Removel from State ortant: If I 3/6/97 R.A. Ferris & Company West Chester, PA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funaral Service Licenses 22. Name and Address of Fecility Hicks Home for Funerals, P.A. 103 West Stockton Street - Elkton, MD 21921 anned & che 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heart feilure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) RESPIRATORY ARREST /Medical Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequenca of): 88 USB Po Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the causs of death? by HEART FALLURE 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy Completed has ATRIAL FIBRILLATION 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 funeral 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Netural 5 Pending Hospital or Attending 24 hours after death.
 Funeral Director: After 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier 1 🗗 certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner es stated. Medical 2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) To the Vithin 2 29b. Signatura and little of cartifier 29c. License number 30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print) UHCCER-EIKTON MD

Registrar

31. Dete filed (Month, Day, Year) MAR 1 1 1997

32. Registrer's Signeture

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State of Maryland / Department of Health and Mental Hygiene

08263 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month William J. Guv March 5, 1997 0640 /Medicai 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Anne Arundel General Hosptial Annapolis Anne Arundel if Under 1 Year if Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) July 12, 1 Birthplace (State or Foreign Country) **Funeral** Months Deys 1⊠M 2□ F 76 003-05-0733 Yrs Director 1920 Manchester, N.H. Usual Residence of Decedent r 28a-f show notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryla 1 ☐ Yes 2 XNo Maryland Anne Arundel Director Annapolis 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? b the Medical Examiner must be 930 Astern Way Apt 103 Herrie 23a 21401 United States Funeral Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Maritel Status 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Black, White, etc. 72 hours after Yes 2 □ No PYes, Give Year or Dates: 1 Never Married 2 Married 1 Yes ZENo altimore, Maryland 21215-0020 "natural", or Specify. White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government Civil Service nemit. Pages 1 and 2 should be filed Department of Health and Mental Hygh reportant: If them 27 is marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Michael Guy 2 Helen Thornton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 930 Astern Way Apt 103, Annapolis, Md 21401 Margaret Guy 20b. Place of Disposition (Neme of cemetery, crematory or other piace) March 10219 199 720c. Location - City or Town, State 20a. Method of Disposition XX Burlai 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Cheltenham, Maryland 21. Signature of Funeral Service License 22. Name end Address of Facilitiese Funeral Home, Inc 6633 Old Alexandria Ferry Rd, Clinton, Md 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Mysiardial infarction diseese or condition resulting in death) immediale **Examiner** Examiner year COTONARY arkery attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detac 1 Yes 2 No 3 Probably 4 Unknown melliter Diatrobes Records, þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24e. Was an autopsy performed? 1□ Yes 2XNo certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p Be 25. Was cese referred to medical 28. Place of Death (Check only one) examiner? Hospital: 1 Sinpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 5, 1997 D383 88 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 8926 Woodyard Road Ste601 Clinton MD 20735 Sunil K. Nachnani, MD 31. Dete filed (Month Rev Year) 1 32. Register's Signature fals division Rendell State

DHMH 16 Bev 6/95

Registrar

PRAM , SROT F.,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Daath **Physician** Month Charles Charles (If not institution, give street and number) Februs 34 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Examiner LAUREL REGIONAL HOSPITAL County If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 6 Sax 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 110M 2□ F Days Min. Yrs. Director 577-05-8731 96 DEC. 7, 1901 BETHEL, N.C. Usuel Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show must be notified at Director 1X Yes 2 No MD PRINCE GEORGES TEMPLE HILLS 200 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? à Herms 23a 9512 TEMPLE HILLS RD 20735 UNITED STATES Funeral 12. Wes Decedant Ever In U,S. Armed Forces? 1 ☐ Yas 2 ☐ No if Yas, Giva Yaar or Detas: 11. Maritel Status Was Dacedant of Hispenic Orlgin? (Specify Yas or No-It Yas, specify Cuben, Maxicen, Puarto Ricen, atc.) 14. Race - American Indian, Black, White, atc. 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 'natural', or 1 ☐ Yas 2 No Specify: Specify: BLACK py 3 Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highast grade complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Hygiene. Elamentary/Secondary (0-12) Collega (1-4or 5+) CUSTODIAN PRIVATE 17. Father's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maldan Sumama) Be Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked a any injury or other 2 BEN GRAY HARRIET LITTLE 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) IRENE D. GRAY /WIFE 9512 TEMPLE HILLS RD TEMPLE HILLS, MD 20735 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cametary, cramatory or other place) 20c. Location - City or Town, Stata 1 Burlal 2 ☐ Crametion 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Brown Hill Cemetery 3/3/97 Greenville, NC 22. Name end Addrass of Facility ALEXANDER S. POPE FUNERAL HOMES 10 5538 MARLBORO PIKE FORESTVILLE, MD 20747 callions there exists the death. Do not antar the mode of dying, such as cardiac or raspiratory errast, the cause of each lina. Approximete Interval Batween Onset and Deeth **Physician** REBROVASCULAR ACCIDENT Immediata Causa (Final disaasa or condition resulting in deeth) /Medical Examiner Physiclan/Medical Examiner physician and the burial-transit requires that the death certificate be executed Sequantially list conditions, if eny, laading to Immadiata causa. Entar Underlying Cause (Disaasa or Injury that Initiated evants resulting In death) Last Due to (or as a consequance of): Box 68760, Due to (or as a consequence of) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? NEUMONIA 1 Yes 2 No 3 Probably 4 Unknown Records, þ director, page 2 should 24b. Wara eutopsy findings evelleble prior to complation of causa of death? Completed 24e. Was an autopsy performed? The law Vital 1 🗆 Yas 2 PNO 1 Yas 2 10 Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certific Be 25. Was casa ratarred to medicel axaminar? 26. Placa of Daath (Check only ona) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Hospital: 2 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA Division of 27. Manner of Death 28e. Data of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Dascribe how injury occurred 1 Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not ba 3 Suicide 28a. Place of Injury - At homa, farm, streat, tactory, office building, atc. (Specify) 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. Medical (Check only To the I within 2 29b. Signeture end titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 124997 30. Nema and address of person who complated ceuse of daath (Item 23e) (Type, Print)

LUIS A. CASAS MI) 8317 CHERRY LA. LAUREL 31. Date tiled (Month, Dey, Year) 32 Registrar's Signatura State Registrar MAR 03 1997

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

08265

FEBRUARY 26, 1997

3001 HOSPITAL PRIVE, CHEVERLY, MARYLANIU 2075

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

3. Time of Death

Funeral

Director

the Maryland 28a-f show must be notified at ó items 23e 72 hours efter ò "natural", ifiled within 7 I Hygiene.

Baltimore, Maryland 21215-0020 permit. Peges 1 and 2 should be filed will Depertment of Health and Mentel Physien, Important: If item 27 is merked other that any injury or other traumatic event, Iffall once.

> **Physician** /Medical **Examiner**

Box 68760

P.O. I

Records,

Division of Vital

certificate be executed signed b page 2 s certificate Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifics itely filled in by the funeral director, I To the Hospital o within 24 hours of To the Funeral Di completely filled in

Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location Director MARYLAND PRINCE GEORGE'S SUITLAND 10e. Street and Number 10f. Zip Code 3716 SWANN RD. 20746 Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: by 30XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CLERK 8th 17. Father's Name (First, Middle, Last) Be JOHN F. NEWMAN ROSE PROCTOR 19a. Informant's Name/Reletionship (Type, Print) MILDRED N. LYON / DAUGHTER 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date XX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 3 - 1 - 9721. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or complication. hat ceus d the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE Due to (or as a consequence of): Examiner pue the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es a consequence of): Physician/Medicai Due to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. DIABETES MELLITUS þ Be Completed 25. Was cese referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA Yes 2□ No 1º 28a. Date of Injury (Month, Day Year) Menner of Death Certification: 28b. Time of 28c. Injury at Work? Neturel 5 Pending Investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certitier edical (Check only

ed cause of death from 23a) (Type, Print)

JR. M.D. 39 Registrar's Signature

GOLVE

2. Date of Death Month NAOMI GRIGSBY **FEBRUAKY** 25,1997 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S GROW HOSPITAL CAMP SPRINGS MALCOLM If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2)X)XF Yrs. 578-05-4648 93 FEB.15, 1904 WASH., DC 10d. Inside City Limits 1 No 2 No 10g. Citizen of What Country? USA 14. Race - American Indian, Black, White, etc. BLACK 16b Kind of Business/Industry DRY CLEANING 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3716 SWANN RD. SUITLAND, MARYLAND 20746 20c. Location - City or Town, State CLINTON, MD 22. Name and Address of Facility
MARSHALL'S FUNERAL HOME 4308 SUITLAND RD. SUITLAND, MD 20746 Approximate Interval Between Onset and Death 23b. Did tobacco usa contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, and due to the cause(s) and manner as steted.

Madical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) and manner steted. 29c. License number
PEPUTY MEDICAL EXAMINER
D33954
FEBRUARY 26, 191

State Registrar MARIO

31. Date filed (Month, Day, Year)

MAR 04 1997

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State of Maryland / Department of Health and Mental Hygiene 08266 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Yae LAD GROSS 21, 1997 4c. County of Deeth TERESA EBRUARY /Medical Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** 105PITAL
at birthdey) If Under 1 Year OUTHERN MARYLAND PRINCE LIN en GEORGE If Undar 24 Hrs. 5. Sociel Sacurity Number 6. Sex 7. Age (In yrs. lest birthdey) Birthpleca (Stata or Foreign Country) , Funeral Months Deys 1□ M 2\\\ 72 Director 1924 CLINTON, MD 216-22-2719 10a, Stata 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f show must be notified at MARYLAND PRINCE GEORGE'S XX Yes 2 No Director SUITLAND 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò 6011 WALTON AVE. Homs 23a 20746 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 ☐ No If Yes, Giva Yeer or Datas: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Rece - American Indien, Biack, White, etc. 11. Maritel Stetus the Medical Examiner filed within 72 hours after 1 ☐ Never Merried 2 ☐ Married 21215-0020 b 1 ☐ Yes XX No Specify: Specify: BLACK þ 3 Widowed XX Divorced natural Completed 15. Decedent's Education 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work dona during most of working life. DO NOT use retired) DEPT. Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) JUSTICE GOVT. DATA TRANSCRIBER 11th Maryland 17. Fether's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be h and Mental ? 7 is marked of 2 WILLIAM CURTIS LAURA CARTER 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) CHARLES GROSS/ SON important: If item 27 any injury or other to 6011 WALTON AVE. SUITLAND, MARYLAND alfimore, Pages 1 20e. Method of Disposition 20b. Plece of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 1XX uriel 2 ☐ Cremation 3 ☐ Removal from Stete HARMONY MEMORIAL PARK 3-1-97 LANDOVER, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD of Funeral Service Licenses 4308 SUITLAND RD SUITLAND, MARYLAND 20746 23a. Part1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete intervei Between Onsat and Deeth Physician /Medical immediete Ceuse (Final diseese or condition resulting in deeth) **Examiner** Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Couse (Diséase or Injury that Initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760. ettending physician for use as the burie Physician/Medical . the signed by the el Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were sutopsy findings aveilable prior to Completed 24e. Wes en eutopsy performed? been completion of cause of death? certificate has 1 Yes 2 0 NO 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case referred to medical 28. Piece of Deeth (Check only one) axeminer? Other: 4 Nursing Homa 5 Residence 8 Other (Specify, Hospitel: 1 Yes 2 No Medical Certification: To 1 Minpatient 2 ER/Outpatient 3 DOA After this 27. Menner of Death 1 Neturel 28d. Dascribe how injury occurred 28a. Dete of injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 5 Pending investigation deeth. 1 ☐ Yes 2 ☐ No I Director: / 2 Accident 6 Could not ba 3 Suicide 28e. Pieca of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) efter 4 Homicide To the Hospital within 24 hours To the Funerel I Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner stated. completely 29b. Signeture and title of certifier 29s. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (item 23e) (Type, Pfint) 1100 BRANCH AUE, CLINTON BERWA, MD OLD 32 Registrer's Signeture 31. Dete filed (Month, Dey, Year) State

Registrar

MAR 04-1997

32 Registrer's Signeture

DHMH 16 Rev 6/95

Piease Type or Print in Biack Indelibie Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Deeth 3. Time of Death SRAYton FEBRUARY 26 1997 0205 4b. City, Town, or Location of Deeth 4a. Facility Neme (If not institution, give street end number) 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER WICOMICO SALISBURY | Bright | State of Foreign | Windship | State of Birth | Windship | State of Birth | Windship | State of Birth | Windship | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | State of Foreign | St 5. Social Security Number 7. Aga (In yrs. last birthdey) 1™M 2□ F 578-98-9235 31 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 1 Yas 2 □ No Marvland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31724 Kenilworth Dr. 21804 United States 12. Was Decedent Evar in U,S. Armed Forcas? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indien, Black, White, etc. 1⊠ Yas 2 No If Yes, Give Year or Detes: 1 ☐ Nevar Married 2 Married Specify: Black 1 ☐ Yes 2 ☒ No 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th Clergy Religious 17. Father's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Surneme) Gloria A. Simpson Eugene Grayton 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grayton / Wife 31724 Kenilworth Dr. Salisbury, Maryland 21804 Melody 20b. Plece of Disposition (Neme of cematary, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Donation 5 Chemetion 3 Removel from Steta 4 Donation 5 Other (Specify) 3/8/97 Harmony Memorial Park Landover, Maryland 21. Signature of Funerel Sarvice Licensae Alexander S. Pope Funeral Homes 5538 Marlboro Pike/ Forestville, Maryland 20747 23a. Pert1. Enter tha disease, or complications by shock, or heer feilure. List only one cause ed tha death. Do not antar the mode of dying, such es cardiec or respiretory errest, Immediete Cause (Finel diseese or condition resulting in deeth) A105 4A3 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disease or Injury that initiated events rasulting in deeth) Last Due to (or es e consequence of): Dua to (or es a consequance of) Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings availeble prior to completion of cause of deeth? 24a. Was en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Examiner

Physician/Medicai

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Certification: To

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Physician

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Funeral

Director

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Director

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Pages 1 and 2 should be filled within 72 hours after death nent of Health and Mental Hygiene.

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Baltimore, Maryland 21215-0020

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physician end the buriel-transit attending p signed by the a d be detached f funeral

s certificate hes b director, page 2 s

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

24 hours To the Hosp within 24 hor To the Fune completely fi

State

Aller 31. Date filed (Month, Dey, Year)

29b. Signature and title of certifian

25. Wes case referred to medical exeminer?

1 Yes 22 No

27. Menner of Deeth

1 Netural

2 Accident 3 Suicide

4 Homicide

29e. Certifier

MAR 04 1997

5 Pending

investigetion

6 Could not be determined

560 BIVERSIDE 32 Registrar's Signeture

1 M. D

1.☑inpatient 2□ER/Outpatient 3□ DOA

28e. Piece of Injury - At homa, ferm, street, fectory, office building, etc. (Spacify)

28b. Time of

28e. Dete of tnjury (Month, Dey Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) salistury, Md. 21801

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) end manner as stated.

2 Medicat Examiner: On the basis of exeminetion end/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated.

29c. License number

029168

1 Yes 2 No

28. Piace of Deeth (Check only one)

Other: 4 Nursing Homa 5 Residence 8 Other (Specify)

28d. Describe how injury occurred

28f. Location (Streat and Number or Rural Route Number, City or Town, Steta)

Registrar

Administration the said that the said

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month CHARLES GORDON **Physician** GARY JR. 1997 1, MARCH 0940 AM /Medical 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 2507 KORVALE LANE BOWIE PRINCE GEORGES If Under Months If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Jan. 19,1943 5. Social Sacurity Number 7. Aga (In yrs. lest birthday) 9. Birthplece (Steta or Foraign **Funeral** Days 1√2 M 2□ F Hours 54 Washington D.C Director 579 54 8698 Usual Rasidance of Decedant with the Maryland 10a. Stata 10b. County 10c. City, Town or Location ortant: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Experience must be inclined at 10d. Inside City Limits XX Yas 2 No Director Maryland Prince George's 10e. Street and Numbar 10f. Zip Coda 10g. Citizen of What Country? 2507 Korvale Lane 20715 United States death Funeral 12. Was Decadant Evar in U,S. Armed Forces? 1ÆYas 2□No If Yas, Giva Yeer or Datas: 60-6 11. Maritel Status Wes Dacedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Rece - American Indian. permit. Pagas 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene, important: If Item 27 is marked other than "natural" or least yillury or other trainment. Black, Whita, etc. 1 ☐ Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Spacify: Specify à 60 - 613 Widowad 4 Divorced White Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highast grade complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Coltaga (1-4or 5+) General Contractor Self 9 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be 2 Charles G. Gary, Sr. Helene (Unavailable) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. informant's Name/Ralationship (Typa, Print) Kathleen Gary Wife 2507 Korvale Lane Bowie Maryland 20715 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Burial 2 Cramation 3 Ramoval from State Fort Lincoln Cemetery 3/5/97 Brentwood Maryland 4 ☐ Donation 5 ☐ Other (Spacify) Funaral Sarvica Licensee 22. Nama and Addrass of Fecility Robert E. Evans Funeral Home, Inc. 23a. Pert 1. Entar the diseasa, or complications that caused the death. Do not antar the mode of dying, such as cerdiac or raspiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete Interval Batween Onset end Deeth **Physician** Immediata Cause (Finel diseesa or condition rasulting in daath) /Medical Examiner Examiner the burial-transit end Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or Injury Dua to (or as a consequence of) Records, P.O. Box 68760. ettending physician certificata be Physician/Medical that initiated avants rasulting in daath) Last Dua to (or as e consaguance of) use as t for Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 8 24b. Were eutopsy findings evailable prior to Completed 24e. Wes en eutopsy peen performad's complation of ceuse of death? pege 2 The certificate 1 Yas 2□ No 1 Yas 2□ No Division of Vital 25. Was cesa rafarred to medicel axaminar? Be 26. Placa of Daath (Chack only ona) Other: 4 Nursing Homa XXRasidance 6 Other (Specify) 10 XIXYas 2□ No 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA this 27. Manner of Daath 28a. Data of Injury (Month, Day Yaar) 28c. Injury at Work? To the Hospital or Attending PI within 24 hours after daath.

To the Funeral Director: After the completely filled in by the funera Certification: 28b. Tima of 28d. Dascribe how Injury occurred Aftert 1 PNatural 5 Pending invastigation 1 Yas 2 No 2 Accidant 6 ☐ Could not ba datarmined 3 ☐ Suicide 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Numbar, City or Town, Stata) 4 I Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

XXMadical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Cartifian (Check only 29b. Signatura and titla of certifiar 29c. License number 29d, Date signed (Month, Day, Year) O.C.M.E MARCH 2, 1997 30. Nama end addrass of parson who complated causa of death (Itam 23a) (Type, Print) Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201 31. Data filed (Month, Day, Year) 33. Ragistrar's Signatura

Registrar

Mar 0**6 199**7

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death Day Month Voor ADDISON BARBARA JEAN -HASAN 26, FEB. 1997 12AM 4a. Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death 7203 WEBSTER LANE FORT WASHINGTON PRINCE GEORGE'S Hours Min. 8. Data of Birth (Month, Say, May 19, 7. Age (In yrs. last birthday) If Under 1 Year 5. Sociel Sacurity Number 9. Birthplece (Stete or Foraign 1 M 2 F Months Days 60 BALTIMORE, MD Vrs 579-46-2576 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 XYes 2 No MARYLAND PRINCE GEORGE'S FORT WASHINGTON 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 7203 WEBSTER LANE 20744 USA 12. Wes Dacedant Evar in U,S Armed Forces? Was Decedant of Hispenic Origin? (Spacify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 1 Naver Married 2 Married 1 ☐ Yas 2 ♣ No If Yas, Giva Yaar or Datas: 1 ☐ Yas 2 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Business/Industry 2+ Collaga (1-4or 5+) Elamantery/Secondary (0-12) NURSE PRIVATE 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maldan Surname) **JOHN** GOODWIN LUCILLE ANDERSON 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straet end Number or Rural Route Numbar, City or Town, Stata, Zip Coda) SALIM HASAN / HUSBAND 7203 WEBSTER LANE FORT WASHINGTON, MD 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Spacify) FNIOMEMENT CEDAR HILL CEMETERY 3-5-1997 SUITLAND, MARYLAND 22. Nama and Addrass of FeciliMARSHALL'S FUNERAL HOME 4308 SUITLAND RD. SUITLAND, MD 20746 Buscoe-love 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. Immediata Causa (Final disaasa or condition rasulting in deeth) ncer-Sgamous cell Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disaasa or injury that initiated avants rasulting in daath) Lest Dua to (or es e consaguance of): Dua to (or es e consequance of) 23b. Did tobacco usa contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings evallable prior to complation of ceuse of death? 24a. Was an autopsy 1 Yas 1 ☐ Yes 2 ☐ No 28. Place of Daeth (Check only ona)

Physician /Medical Examiner

The law requires that the death certificate be executed

P.O. Box 68760,

Division of Vitai Records,

or Attending Physician:

permit. Pages Department of H Important: If he any injury or of once.

Physician

/Medical

Examiner

Funeral

Director

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items 23a or 28a-f

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Mantal if Health and Menta from 27 is merked

Pages 1 and 2 should

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the Medical Examiner

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Maryland 21215-0020

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Funeral

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To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fi

Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Wes cesa ratarre examinar?	
27. Manner of Daath 1 ANatural	5 Panding

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28a. Date of Injury (Month, Day Year)

28b. Tima of

28e. Plece of injury - At home, ferm, streat, factory, office bullding, atc. (Specify)

Othar: 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 1 Yas 2 No

5 Rasidance 6 Othar (Specify) 28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifier (Check only one)

2 Accident

4 T Homicida

3 Suicida

12 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and dua to the cause(s) and manner stated.

29c. Licansa number

29b. Signature and title of certifier

10272-MD

29d. Data signed (Month, Dey, Year)

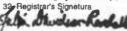
30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

MARIBORD Pike - Dist. Hights, Ind. 20747 ALTER B. SHEER MD. 31. Data filed (Month, Day, Year)

State Registrar

Medical

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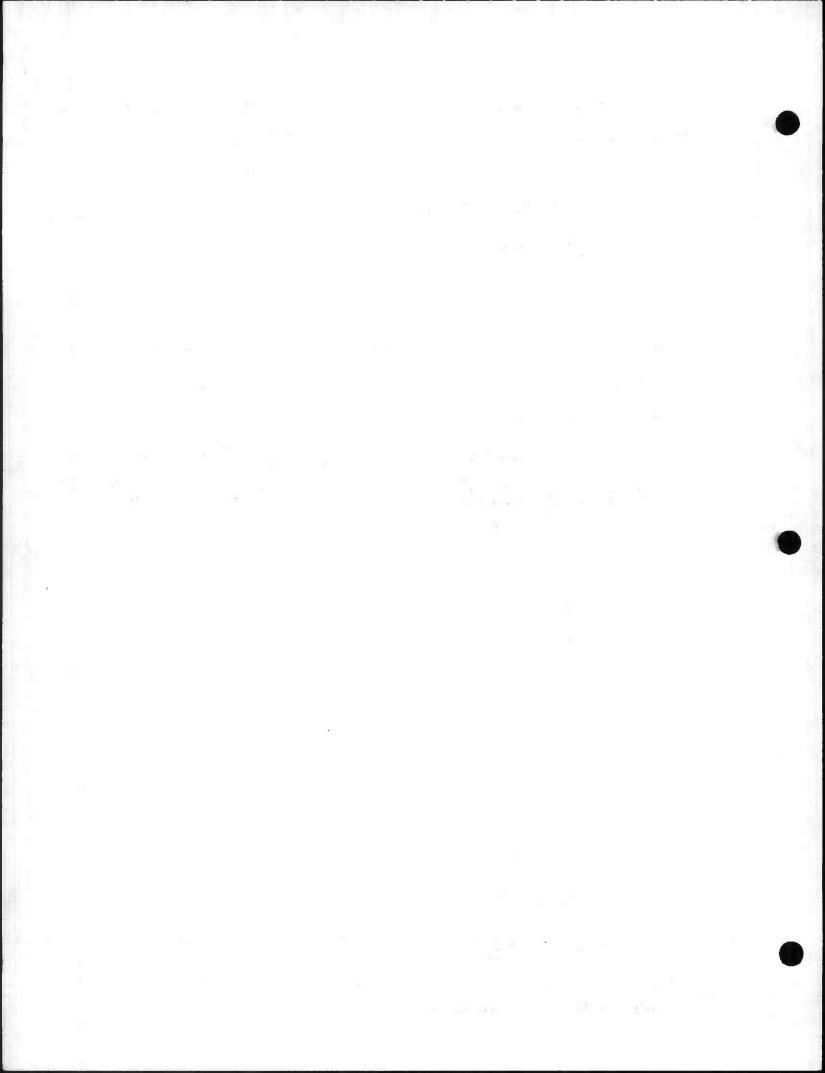
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Dey **Physician** MARCH 1, 1997 J. MILTON HAUGH 6 am /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** WASHINGTON ADVENTIST NURSING HOME TAKOMA PARK MONTGOMERY If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Birthplece (Stete or Foreign Country) Months 1 □ M 2 □ F 214 03 8620 Director Feb 24,1908 Penna. Usuel Residence of Decedent MONTGOMERY TAKOMA OF LOCATION 10d. Inside City Limits the Maryla 28a-f show the Medical Examiner must be notified at Director 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8 7904 GREENWOOD AVE 20912 U.S.A. therms 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 14. Reca - American Indien. hours after 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 X Married Baltimore, Maryland 21215-0020 8 1 Yes ZENo Specify: P 3 ☐ Widowed 4 ☐ Divorcad 'natural'. WHITE Completed 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 12 should be filed within 73 h and Mental Hygiens. Is marked other than "ny Elementery/Secondary (0-12) College (1-4or 5+) SUPERINTENDENT BUILDING INDUSTRY 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 ROSWETT HAUGH **EMMA** SWAB 2 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 an Department of Health and Important: if Nem 27 is m any injury or other traum once. ā MILDRED HAUGH/SPOUSE SAME AS 10e 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete | Burial 2 | Cremetion 3 | Remove | from State | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cremetory of Outer present | Cemerery, Cemerery, Cremetory of Outer present | Cemerery, Cemerery, Cemerery, Cemerery, Cemerery, Cemerery, Cemerery, Cemerery, Cemerery, Cemerery, Cemerery, Cemerery, Cemerery, Cemerery, Cemerery, Ceme 3/5/97 Brentwood, Md. 22. Name end Address of Fecilify TAKOMA FUNERAL HOME INC 254 CARROLL ST N.W. WASHINGTON, D.C. 20012 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest shock, or hear failure. List only one cause on such line. Approximete intervel Between Onset and Deeth **Physician** Cow /Medicai Immediete Ceuse (Final diseese or condition resulting in deeth) ARRHYTHMIA minutes Examiner Due to (or es e consequence of) Examiner sician and bunal-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest Due to (or es a consequence of): physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): 80 980 Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. 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Route Number, City or Town, Stete) filled in by 4 Homicide 24 hours a Hospital 1 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) and menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, and due to the ceuse(s) and menner steted. 29e. Certifier Medical completely (Check only one) within 2 To the 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D42518 MAR 03, 1997 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

GUL CHAVSUANI, 11119 Rockevur Pitt #316 Rockevur, 2085 Registrar's Signeture

DHMH 16 Rev 6/95

State Registrar



State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene 08272 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Deeth 3. Time of Death **Physician** Month Clarke 1, 1997 Hawkins March 7:15 AM /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Care Matrix N.H. Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1**X** M 2□ F 78 Vrs 579-09-2682 19, 1918 Washington D. Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Rockville 10e. Street end Number 10f. Zip Code 10a, Citizen of What Country? 20853 4811 Eades St. U.S.A. 12. Was Decedent Ever In U,S. Armed Forces? .1 ☐ Yes ≥ ₹ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritai Status 1 Married 2 Married 2 Married 1 ☐ Yes 2 No Specify: ρ 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NONE N/A 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ira C. Hawkins Murray Adams 19a. Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys Hawkins (Sister in law) 1205 Grandview Ave. Fort Gibson, Oklahoma 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glenwood Cemetery Washington D.C. 21. Signature of Funeral Service Liganage 22. Name and Address of Fecility Chambers Funeral Homes, P.A. 670 5801 Cleveland Ave. Riverdale, MD. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequenca of): Part ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Piece of Death (Check only one) Other: 42 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatlent 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner-steed. 29b. Signeture and title of certifier 29c. License number 29d. Date-signed (Month, Day, Year) death (Item 23e) (Type, Print)

State Registrar

Funeral

Director

25a-f show must be notified at

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items 23a

'natural', or

altimore, Maryland 21215-0020

2 should be fi and Mental F marked

important: If item 27 is

Physician /Medical

Examiner

ician and burial-trans

signed by the

page 2 should

certificate

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica stelly filled in by the funeral director, g

To the Hospital within 24 hours a To the Funeral Completely filled

3

the th

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

31. Date filed (Month, Day, Year) MAR 0 4 1997

32. Registrar's Signature

The trace becomes the C. La Tito St. FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First									2. DATE OF DEATH			3. TIME OF DEATH
	ELM	YER.	HOME	S							-6	97	9:001
	4. SOCIAL SECURITY NUME		5. SEX	8. AGE (In yrs. last	t birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS	7. DATE OF BIRTH	-0	, ,	PLACE (State or Foreign
	231-36-0869		1 X XM 2 □ F		1 YRS.	MONTHS	DAYS	HOURS	MIN.	August 27,	1033	Country	ginia
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6	RESIDENCE OF DEC		01000				OTT.	ege 1	alk		F	TIICE	George s
E I	10a. STATE	10b. COUNTY			10c. CIT	r, TOWN C	R LOCA	TION					10d. INSIDE CITY
DIRECTOR	Maryland	Princ	e George	e's	Co	11eg	e Pa	ark				- 4	1 HES 2 NO
귛	10e. STREET AND NUMBER						10	. ZIP CODE	E	-	10g. CI1		HAT COUNTRY?
EB	5113 Lacka	wanna	Street					2074	10		U	nited	States
FUNERAL	11. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN U.S. ARI	ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specif					IC ORIGIN? (Specify Ye	s or No-	14. RACE	American Indian,
	1 Never Married 2		FORCES?	YES 2 N	□ NO If yes, specify Cuben, Maxicen, Puerto Ricen, etc. 1 □ YES 3 □ NO Specify:							Black, Specify	White, atc.
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₹		2		Med	chani	С				Heatin	g and	d A.C	•
COMPLETED	17. FATHER'S NAME (First, M Earl	liddle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gladys Smith							
BE			Hayes					[+]	Ladys	<u> </u>		Sm	itn
2	Patty Ann W	Type/Print)	(Daugh+	(ar) 19b	MAILINO			and Number	or Rumi A	loute Number, City or Tox	vn, State, Zi	p Code)	
			Daugiit	, ,	Sauce	as	#10						
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	4 Donation 5 Other 21. SIGNATURE OF FUNERA			<u> Maryla</u>	and V	eter	ans	Ceme	etery	13/4/1997	Che:	Ltenh	am, Maryland
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) was	V-F	30 MW	Oct.		44	00 1	Powde	r Mi	11 Road B	elts	ville	, P.A. , Md. 20705
Ĭ	23. PART i. Enter the di	Iseasea, Dr	omplicetions the	it ceused the de	ath. Do n								Approximate
	IMMEDIATE CAUSE (FIR		List Drily One Car	ase on each line.									Interval Between Onset and Death
	disease or condition resulting in death)	→ .		Car	CER	: 0	=	Lun	36				Loomos
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Ė	thet initiated events resulting in death) LAS	т .	DUE 10	(OR AS A CONSEC	UENCE OF	·):							
CERTIFICATION		0	l		_								
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MEDICAL										PERFO	RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
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¥	25. WAS CASE REFERRED TO				E OF DEAT		_	2 0110		, ,			
Sic	EXAMINER?		HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER		. s\/80	aldanca 1	8 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH		28a. DATE OF	INJURY	28b. TIMI	E OF	28c. INJ	URY AT	SIGNIC C	28d. DESCRIBE HOW	INJURY OC	CURED	
	7 7	Pending	(Month, L	Pay, Year)	INJ	URY M	1 🗆 '	YES 2	ON				
BÝ	2 0 0 1 1 1	Investigation Could not be	28a. PLACE C	F INJURY — At hor	ne, farm, s	treet, fact	ory, offic		1	28f. LOCATION (Street	and Numbe	r or Rural Ro	oute Number
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COMPLET													and manner as stated.
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	31. DATE FILED (Month, Day,	Year)	12 BEGISTE	AR'S SIGNATURE	-	100		U-0	70	7 07	Jul	mu	راد اس
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

10 2

DHMH-18 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08274 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Carolyn Hodnett March 5, 10:15 AM 1997 4e. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 4940 Sentinel Drive #106 Bethesda Montgomery If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Yeer 8. Date of Birth (Month, Day, Year) May 2, 1935 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) Oklahoma 1□M 2X0F 442-36-6300 61 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 ☑ No

Baltimore, Maryland 21215-0020 Physician /Medica Examine

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health end Mantal Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at Ance

Physician

/Medical

Examiner

10a. State

Funeral

Director

To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit

Division of Vital Records, P.O. Box 68760,

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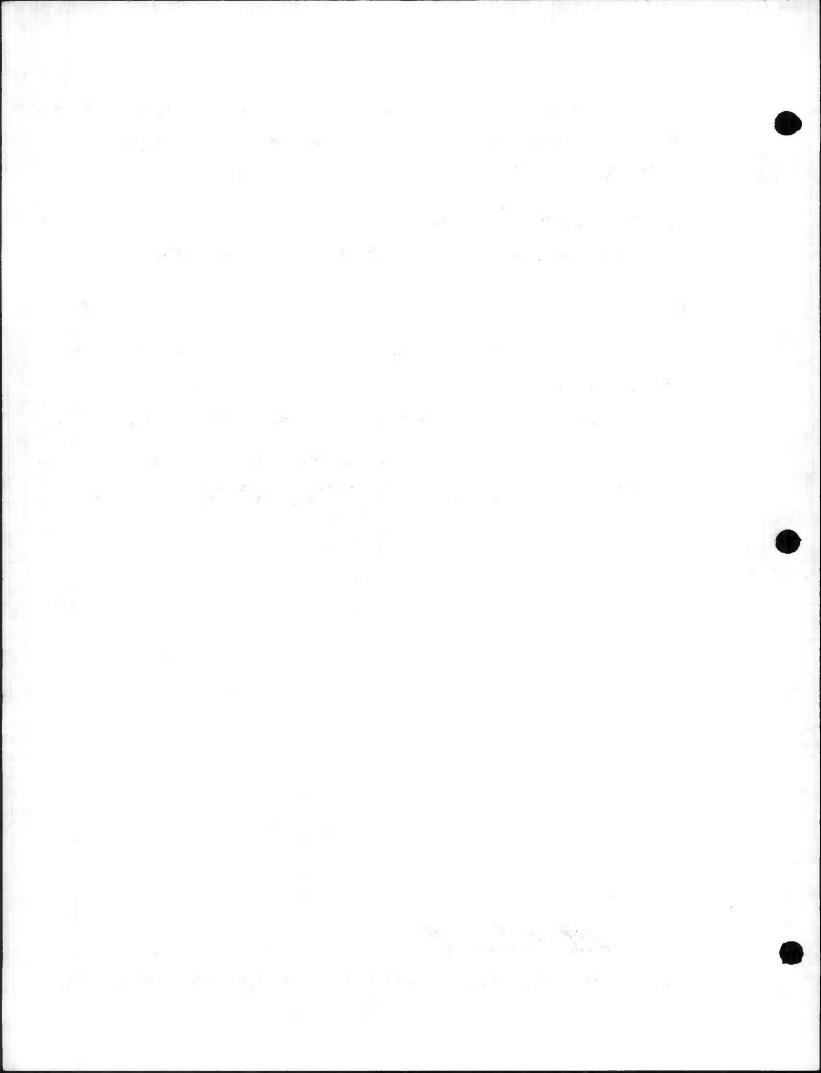
Maryland Montgom	iery Bet	tnesda						1 162 5 M
10e. Street and Number		1	Of. Zip Code			10g. Citizen of	What Countr	y?
4940 Sentinel Dri	ve #106		20816			United	State	S
11. Maritel Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Wes Decedent Ever in I Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			spanic Origin? (S n, Mexicen, Puer Specify:	Specify Yes or No to Ricen, etc.)	14. Rad Bia Specif	ce - America ck, White, et	tc.
15. Decedent's E		16a. Decedent's	s Usuei Occupa	tion		16b. Kind of B		
(Specify only highest gr Elementary/Secondary (0-12) 12	College (1-4or 5+)	(Give kind life. DO N Teach	of work done d VOT use retired)	uring most of wo	rking	Private		
17. Father's Name (First, Middle, Las		, , , ,		18. Mother's Na	me (First, Middle,			
Raymond A. Yo	oung			Verna				
19e. Informant's Name/Relationship	(Type, Print)				ural Route Numbe			
Jonathan Hodnett				ie Cour	t, Fairf	ax, Vir	ginia	22033
20a. Method of Disposition 1 ☐ Buriai 2 ☑ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	Place of Disposition cometery, cremator	ry or other place	<i>'</i>	Date	20c. Location		
21. Signature of Funeral Service Lice	nsee / Rep	Rapp 933	me and Address Funera Gist Av	s of Facility 11 Servi enue. S	ces, P.A ilver Sp	rina. M		Maryland and 20910
23a. Part1. Enter the disease, or con shock, or heart feilure. List only	nplications that ceused the dea one ceuse on each line.	th. Do not enter the	e mode of dying	, such as cerdia	c or respiratory ar	rest,	1 6	Approximate Interval Between Onset end Death
immediete Cause (Final disease or condition resulting in death)	a. Metastati	c Breast	Cancer				1:	1 years
	Due to (or es a consequend	ce of):					
	b		,				i	
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initieted events	c	or as a consequenc						-11/
resulting in deeth) Last	d	or as a consequenc	a or):					
Pert ii. Other significant conditions	contributing to death but not re-	sulting in the underly	ylng ceuse give	n in Part i.	23b. Did t	obacco uss co	ntribute to t	the causs of death?
					10	Yes 3 No	3 Proba	ibly 4 ☐ Unknown
					24e. Was perfo	an autopsy med?	comp	e eutopsy tindings lable prior to pletion of cause eeth?
					101	es 2 No	10	Yes 2 No
25. Was cese referred to medicel				26. Place of Dea	ath (Check only o	ne)		
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 inpatient 2	ER/Outpetient 3	DOA Othe	7.	lome 5 ☑ Resid		er (Specify)	
27. Menner of Death 1 Neturai 5 Pending 2 Accident Investigatio	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe			-1_3
3 Suicide 6 Could not be determined		nome, ferm, street, f	actory, offica		28f. Location (S City or Ton	Street and Numb m, State)	per or Rural F	Route Number, '
29e. Certifying Pt (Check only one)	nysician: To the best of my kno miner: On the basis of examine end manner stated.	owiedge, deeth occu etion end/or investig	urred et the time petion, in my opi	, date and plece nion, deeth occu	o, and due to the d pried at the time, d	cause(s) and middle and piece,	inner as stat and due to th	ted. he ceuse(s)
29b. Signature end title of ce	,/	0	29c. License	number		29d. Date signe	d (Month, De	ay, Year)
MIN).	Mund		DC135	67	M	arch 5,	1997	
30. Name and address of person who				ND 4 " 0	401			00007
Robert S. Siegel, 31. Date filed (Month, Day, Year)	M. U. 2151 Pe	ennsylvan	ia Ave.	NW #3-4	431, Was	nington	, D.C.	2003/
	32. Registrar's 3gg	a Davidson-1	fandell.					

DHMH 16 Rsv 6/95

State

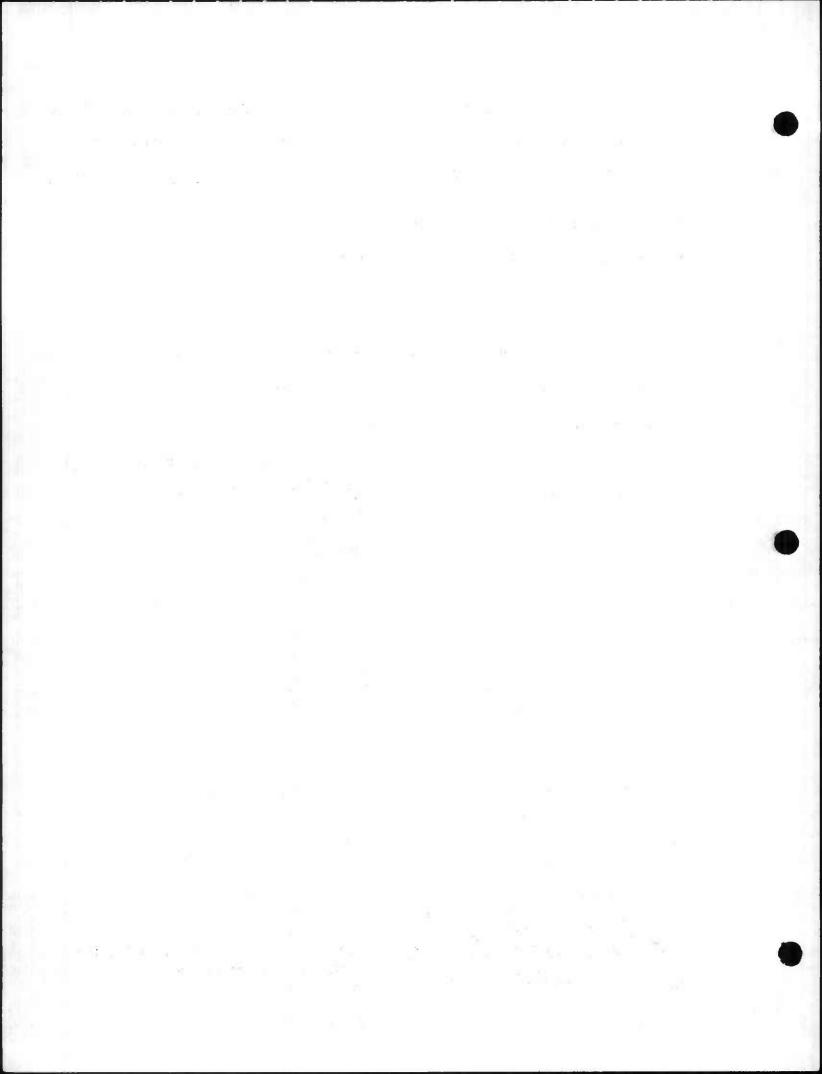
Registrar

MAR 0



State of Maryland / Department of Health and Mental Hygiene

						Cei	rtificate d	of Deat	h		Reg.	No.		00	- 10
			1. Decedent's Name (First, Middle,	Lest)						2. Date of D	eeth			3. Tim	e of Deeth
	Physic		Ma	rgery C.	Hoenac	k				Februa		25,	Yeer 1997	12	:20 AM
	/Medi		4a. Fecility Name (If not institution, g	- J		· K		4h City	Town or L	ocation of Dee				12	.ZU AII
7	Exami	ner								DOGULOT OF DOG	7.01	4c. County			
			8409 Old Seven				Milliander d Ma		nesda				tgomer	•	
	Funeral			Sex 7. / 1□ M 27 F	Age (In yrs. lest	Yrs.	If Under 1 Ye Months De		er 24 Hrs. Min.	8. Date of B (Month, D	irth ley, Ye	ar)	9. Birthple	ace (Ste	ete or Foreign
S 15	Director		536-03-9697	 	80	115.				March 6			Washi		
Pu	3		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	um or Lo	antion					1			
Z	show	1			Too. Oily, To	WIT OF LO	Cation						10		e City Limits
2	18	Sct	Maryland Montgo	mery	Bethe	esda								1 []	res 2X No
ē	2 2	Director	10e. Street end Number				10f. Zip Cod	0			10g.	Citizen of	Whet Count	try?	
11215-0020 within 72 hours after death with the Maryland	el', or items 23a or 28a-f shov Examiner must be notified at	a.	8409 01d Seven L	ocks Road			2081	7			Un	ited	State	S	
dea	# S	Funeral	11. Maritel Stetus	12. Was Deceden	t Ever in U,S.	13. \	Was Decedent of f Yes, specify C	of Hispanic C	Origin? (Sp	ecify Yes or N		14. Rac	e - Americe	en Indier	١,
o te	5 5		1 Never Married 2 Married	1 Yes 2						Hican, etc.)		Bia	ck, White, e	etc.	
02 drs	- 1	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		1□Yes 21X	No Specif	fy:			Specif	y: Wh	ite	
2-0-5	"neturel",	Completed	15. Decedent's	Educetion	16	a. Deced	dent's Usuel Oc	cupetion	T		18b	. Kind of B	usiness/Indi		
215 7 nin 7	- 2	pie	(Specify only highest g			(Give	kind of work do DO NOT use rea	ne durina me	ost of work	ing					
Villa Villa	Hygiene. other than	E	Elementary/Secondery (0-12)	College (1-4or		lusio	Educat	tor			F	ducat	ion		
THOU N	d other		17. Fether's Name (First, Middle, Le			10510	Laaca		her's Name	e (First, Middle	-			-	
ج م م		Be	Herbert M. Co	LINCO							.,				
aryla should	marked matic e	1º		urse						lart				_	
Maryland 21215-0020 d 2 should be filed within 72 hours af	8 8 B		19a. Informent's Name/Reletionship		15		ng Address (Str	eet end Num	iber or Run	el Route Numi	ber, Ci	ty or Town,	Stete, Zip (Code)	
	other tr		August F. Hoena	ck			e as 10								
0 %	5 2 5		20a. Method of Disposition 1 Duriel 2 Cremation 3	□Removal from State		ery, cren	sition (Neme of netory or other)	olece)		Dete	20c	Location -	City or Tov	vn, Stete	
Baltimore,	ury o	١.	4 □ Donation 5 □ Other (Spec			sape	ake Ci	remat	orv3	-6-97	Be	ltsvi	11e, 1	Mary	land
a E	Department Important: h any injury o		21. Signature of Funeral Service Lic	ensee/)	1	Name and Adapp Fun						,	101	Turiu
m §	Depa Impo any ir		1 / m. 5	W R	20	K.	app Fun	erals	servi	ces, P.	A.	na I	MD 20	0910	
	_	-	29a Parti Error the diseases or on	mailtantines that course	17		33 Gist					ing, i			
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirato shock, or heart failure. List only one cause on each line.												Interval	mete Between
	ysician													Onsei a	nd Death
	Medical caminer		fmmediate Ceuse (Final disease or condition	a Pancrea	atic Car	cer							m	ontl	15
		L.	resulting In deeth)		Due to (or as		uence of):						1		
P	- 4	ine.	_												
cute	rans	Examiner	Sequentially list conditions.	D	Due to (or es	conseq	uence of):								
o š	an a		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury												
OX 58/50, certificate be executed	physician and s the burial-transit	n/Medical	met initiated events	C	Due to (or es	consequ	uence of):								
tifica o	as t	Jed	resulting in deeth) Lest		,	,	,								
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de ath	ed by the atte	Physician	Port II Other eignificant conditions	annish vilan in denth	h	L. Mr. T.	4.14.6	-1		L con pu					
Tat the G	by the tached	ys	Pert II. Other significant conditions	contributing to death	out not resulting	in the un	iderlying cause	given in Pan	t I.	23b. Did	tobec	co uaa co			se of death?
	ed b deta									10	Yss	2 No	3 Probe	ably 4	Unknown
VITAL RECORDS,	been signed t should be det	l by							_						
lecords	nouli	Completed								24e. Was	s an au ormed		ave	leble pri	sy findings or to
\$ C	0 N	pid											of de	eath?	of cause
E &		0								10	Yes	2 D(No	1 🗆	Yes 2	2X No
E ::	certificate rector, pay	Be	25. Was cese referred to medical					26 Plea	ce of Deeth	(Check only					W
	is certifica director,	ToE	examiner? 1 Yes 2 No	Hospitel:	ient 2 ER/C	utnation	3 DOA	Other				6 DO#	(0:4-)		
2 5	長 南		27. Manner of Deeth	28a. Dete of Inj		Time of				me 5 Res 28d. Describe					
O I Attending Phys	Afte fundament	tior	1 Naturel 5 Pending investigation	(Month, De	ay Year)	Injury	28c. In V					naily occur			
Te Le	deat tor: / the	ica	2 Accident investigation 3 Suicide 6 Could not be determined elements. Suicide 10 Suicide 28e. Plece of injury - At home, ferm, street, factory, office							not Location	(04			0	Control Control
٥٠ ٨	Mrec in by	Certification:	4 ☐ Homicide determine	building, e	tc. (Specify)	erm, stre	et, factory, offic	e		28f. Location (City or To	wn, St	era rvuma ete)	er or Hurai	Houte N	/um <i>ber,</i>
is in	ralc														
8	ely fe	edical	29a. Certifier 17 Cartifying P	hyalcian: To the best miner: On the basis of	of my knowledg	e, death	occurred at the	time, dete a	ind place, e	and due to the	ceuse	(s) and me	nner es sta	ted.	
2	within 24 hours after death. To the Funeral Director: After completely filled in by the funer	8	one)	end manner s	tated.		oanganon, in m	y openion, de	au occurr	ov at the time,	U210 8	and place,	and due to t	III COUS	e(S)
Tot	Tot	Σ	29b. Signatury and this of partition	2 /	1		29c. Lice	nse number			29d. (Date signer	d (Month, D	ey, Yea	r)
			X/ Kull	when U	2. 1	MA	D25	2854			Ech	MILLAMI	25	100	7
	15		30. Name and address of person who	Munk	11	7//				-1.			25,	199	
			G. Nicholas Roge			(Type, F	1001			cut Av		е			
			31. Date filed (Month, Day, Year)				Kens	ingto	n, M	D 208	95				
	Sta	te	o Dato mod (month, Day, real)	32. Hegist	ra Signature		W								



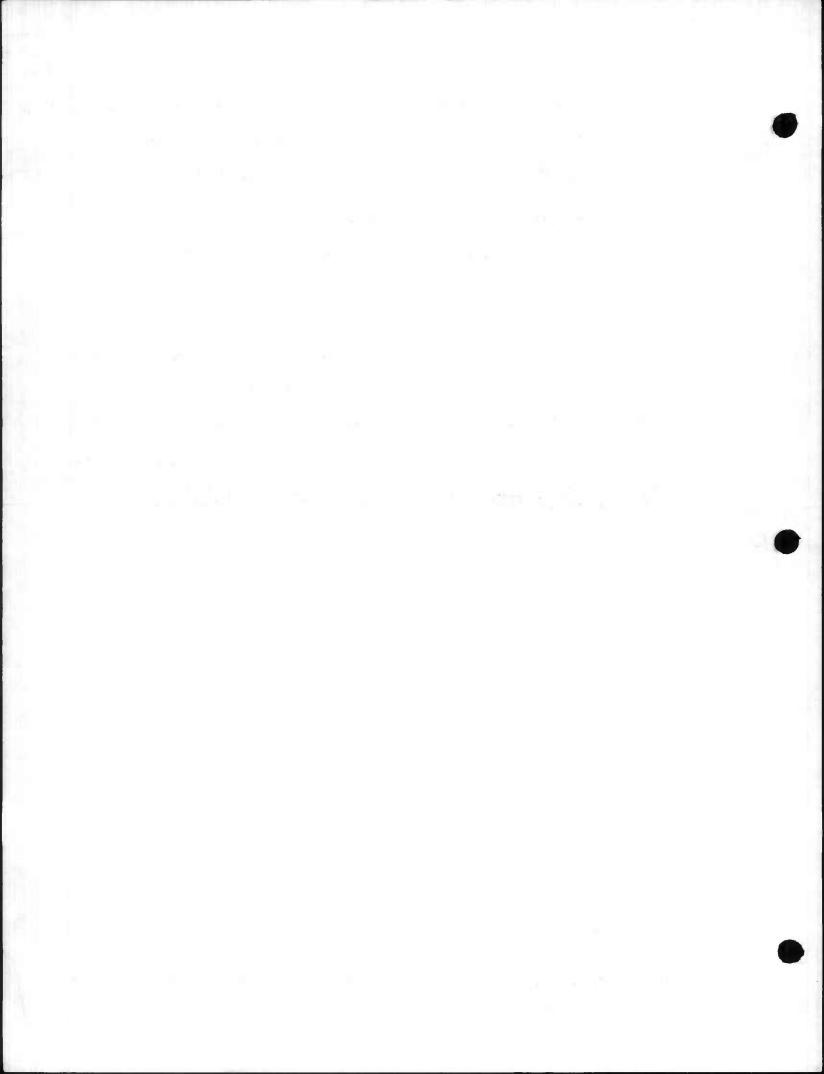
It	ems:	23 part I,II,27,28a-					Health and I	vieniai ny	Reg. No.	7 0	8276
Physici	_	1. Decedant's Nama (First, Middla, L PETER A		RMUTH	-I			2. Data of Do Month FEB	Day	Year . 997	3. Tima of Death 9:50 P
/Media Examir	_	4a. Facility Name (If not institution, gi	va street and number)				4b. City, Town, or	-			9:30 P
-Aum		807 QUINCE OR	CHARD BL	VD.#1	11		GAITHER	RSBURG	MONT	GOMER	Y
Funeral Director		5. Social Security Number 6. 213-78-9714 Usual Rasidance of Decedent	Sax 1∭ M 2□ F	a (In yrs. Ia. 35	st birthday) Yrs.	If Undar 1 Ya		8. Data of Bi (Month, Di April	rth ay, Year)	9. Birthpled Country	gton, D
word at	tor	10a. Stata 10b. County Maryland Montgor	nerv	10c. City,	Town or Loc	ersburg				10d.	inside City Limi
28	Director	10e. Street and Number			OGION	10f. Zip Code			10g. Citizen of	What Country	7
38.0		807 Quince Orchan	d Blvd.,	<i>‡</i> 1 1		2087	8		United	States	
in "natural", or items 23a or 28a-f show Medical Examiner must be notified at	Funeral	11. Marital Status 1 ☑ Navar Marriad 2 ☐ Married	12. Was Dacedant Armed Forcas? 1 \(\superscript{Yas} 2 \subsection{\text{X}}				f Hispanic Origin? (Suban, Maxicen, Puarl	pecify Yas or No o Ricen, atc.)		ce - Amarican ck, Whita, etc	
E. E.	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giva Yaar or Datas:		1	□Yas 2⊠N	o Specify:	Specify:			
n nat	Completed	15. Decedent's E (Specify only highast gr Elamantary/Secondary (0-12)	ducetion ade complated) Collega (1-4or t	5+)			upation a during most of wor red)	king	16b. Kind of 8	usinass/Indus	atry
Con he	Co	12			T	echnici	.cian Appliance Repa				
la b	Be	17. Father's Nama (First, Middla, Las					1000000	na)			
nd Mental marked c	ို	Rudolf P. Hor						A. Pisk			
0 0 0	Rudo.	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Streat end Number or Rurel Routa Number, City or Town, Stata, Rudolf P Hormuth / Father 3 Rasildon Circle Pockwille Marvyland									850
		Rudolf P. Hormuth / Father 3 Basildon Circle, Rockville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Data 20c. Location - City or									
0 = 0		1 □XBurial 2 □ Cramation 3 □		cen	matary, cram	atory or other p					
rtant	4 Donation 5 Other (Specify) St. Mary's Cemetery Feb. 17, 1997 Rockville, Mar 21. Signature of Funeral Sarvica Licansae 22. Nama and Addrass of Facility Robert A. Pumphrey Funer										
Depa Impo any ir once.		Michele 9.	41.	400348	Ro	ckville	, Inc., 3 , Marylan	00 W. Mo	ontgomer	y Aven	eral Ho
hysician /Medical xaminer	ner	Immediata Causa (Final disease or condition rasulting in death)	ACUTE ETH		NTOXICA						
ed by the ettending physicien end detached for use as the burial-trensit	ical Examiner	Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or Injury that initiated events	b		as a consaquas a consequ						
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y the ett ached fo	hysici	Part II. Other significant conditions	contributing to deeth b	ut not rasult	ing In tha un	darlying ceusa	givan in Part I.		tobacco use co		
gned be det	by P	SEIZURE DISORDER						1	700 2010	o_ i ioual	NY YEADING
s been s 2 should	ATHEROSCLEROTIC CARDIOVASCULAR DISEASE						24a. Was peri	an autopsy ormad?	avalla	autopsy finding abla prior to lation of ceusa ath?	
E 80	On							XX	Yas 2□No	1XX	as 2□ No
this certificate rel director, per	Be	25. Was cesa rafarrad to medicel _ gyaminer?					26. Plece of Dea	ath (Check only	one)		
his ce	2	X Yes 2□ No	Hospital: 1 Inpatia	nt 2 E	R/Outpatient	3□ DOA	Othar: 4 D Nursing F	loma 🔏 🖔 Ras	idance 6 □Oti	nar (Specify)	
E =	atlon:	27. Mannar of Death 1 Natural 5 Panding 2 Accident Invastigation		y Year) fo	28b. Tima of ourld ^{ur} at 8:44	28c. in V	juryat /ork? □Yes 2.0000No	28d. Dascribe Unknown	how Injury occu	rred	
rs after death. al Director: After ted in by the funera Certification:								wn. Stata) 807	nber or Rural Route Number, 7 Quince Orchard Bl		
within 24 hours after To the Funeral Directory Completely filled in	edical										
within To the comp	W	29b. Signatura and title of certifiar	A Chen	te m	,		nsa number C . M . E		FEB.	12, 1	
		30. Neme end addrass of person who	completed causa of d	eath (Itam 2	23a) (Type, F	Print)					

State Registrar 31. Date filed (Month, Day, Year)

MAR 0 3 1997

32. Registrar's Signatura

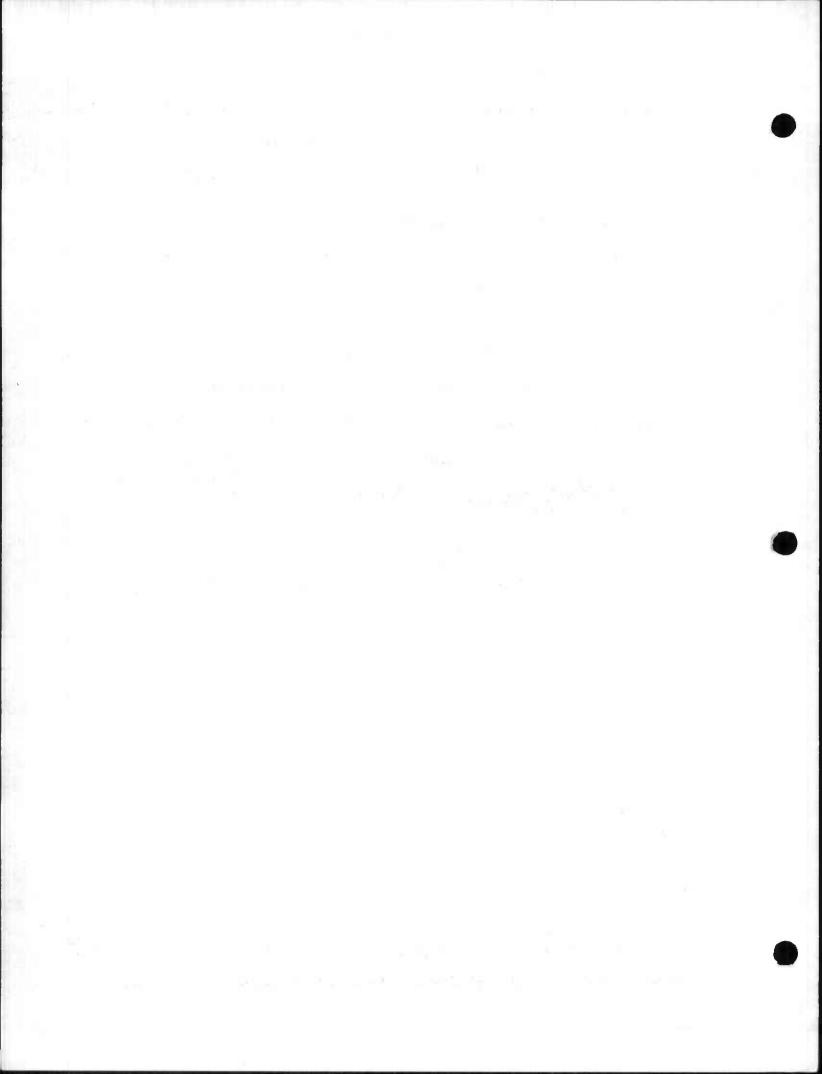
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

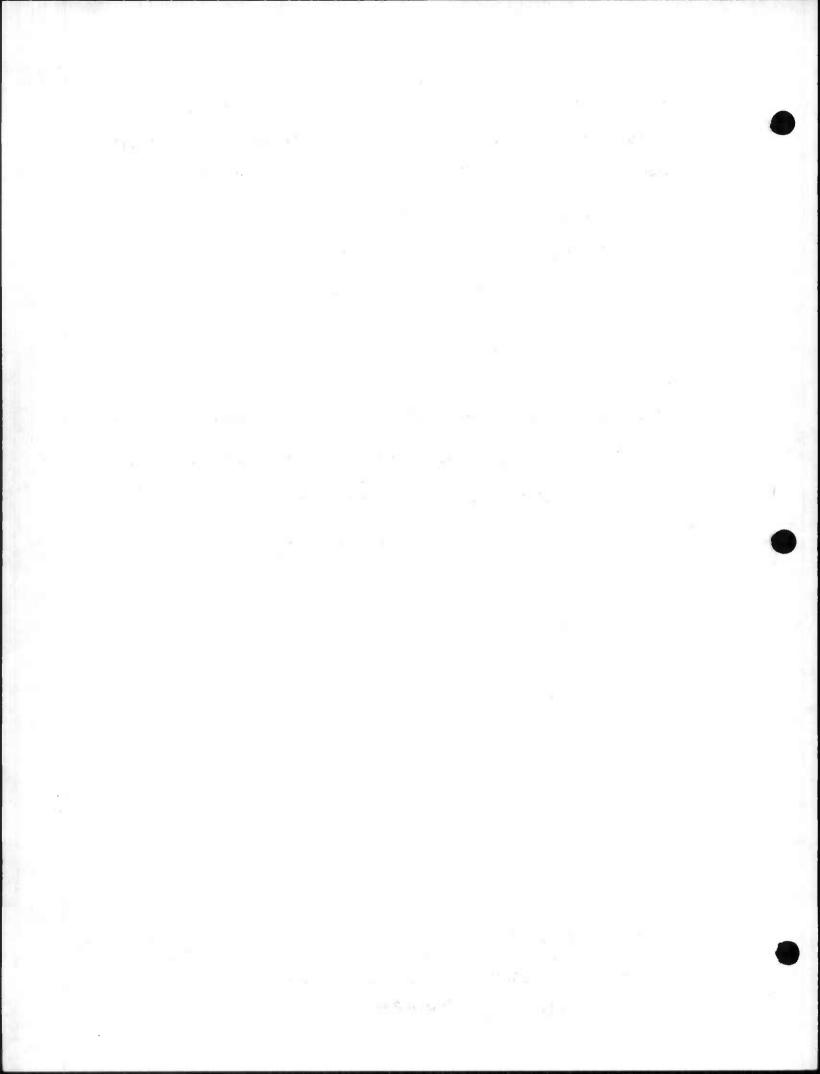
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Physician /Medical	Le		ves Humph		Jr.			2. Dete of D Month March	5, ^{Dey} 1997	Year	3:00 a.m.
Examiner	,		on, give street and n	number)			4b. City, Town, o	r Location of Dee	th 4c. Count	y of Deeth	
-1111	Sub	urban Hos	pital				Bethese	da	Montg	gomery	7
Funerai		curity Number	6. Sex 1 M 2 ☐ F	7. Age (I	n yrs. lest birthd	Months Dey			irth	9. Birthp	plece (Stete or Foreign
Director	071.0	3.4110	1404 M 2 L F	85	Yrs	. Months Day	3 Hours Wil	Nov.14	.1911		chusetts
		ence of Decedent									
in the	10e. Stete	10b. Count	у	10	c. City, Town or	Location				1	Od. Inside City Limits
Items 23e or 28e-f show ther must be notified at Tuneral Director	MD	Montg	omery		Chevy Cl	nase					1 ▼ Yes 2 □ No
2 d o	10e. Street	end Number				10f. Zip Code			10g. Citizen of	Whet Cour	ntry?
Q	4023	Oliver S	treet			20	815		U.S.	A .	
Funeral Director	11. Merital S		12. Wes De	cedent Eve	rin U.S. 1		-	(Specify Ves or N		ce - Americ	ean Indien
Fun /	1	er Merried 2□ Ma	Armed F	Forces?		 Was Decedent of If Yes, specify Cu 	iben, Mexican, Pue	rto Rican, etc.)	Ble	ck, White,	
by 8		owed 4 Divorce	if Yes C	Sive		1 ☐ Yes 2 X N	o Specify:		Specia	y: Whit	e
7	022		7,50	Dates.	10- D-	and and a black One			401 15:115		
Completed		(Specify only high	nt's Education est grade completed	d)	(G	cedent's Usuel Occ ive kind of work don b. DO NOT use reti	e during most of w	orking	16b. Kind of E	susiness/in	dustry
E G	Elemente	ry/Secondary (0-12)		(1-4or 5+)							
				+4	Mai	rine Engi			Buffalo		ge Co.
Be e		Name (First, Middle						eme (First, Middle		me)	
2	Lec	onard Gra	ves Humph	rey,	Sr.		Flore	ence Dale	eno		
5	19a, Inform	ent's Name/Relation	ship (Type, Print)			eiling Address (Stre			ber, City or Town	, State, Zip	Code)
5	Ann Lo	ouise Hum	phrey Dav	ie	2303	Glenmore	e Terrace	Rockv	ille, Md	. 20	850
any injury or other traumatic poss.		of Disposition	part of _Dav_		20b. Plece of Di	sposition (Neme of	()	Dete	20c. Location	- City or To	own, Stete
			3 Removal from	n State		remetory or other p		2/7/07	A1 1		**
	_	netion 5 Other (- 0		Mult CI			3/7/97	Alexand		
BUCB	at Signatur	LA IA	LICENSEE			22. Name end Add		-	wier's S	ons,	Inc.
	•	MUN	111900	6		130 WI AV	AE NM MDC	20016			
10	23a. Pert1.	Enter the disease, or heart fellows	complications that	caused the	deeth. Do not	enter the mode of d	ylng, such es cardi	ec or respiratory	errest,		Approximete Interval Between
s the buriel-transit	diseese or or resulting in	death)	b. W	alc	to (or es a con	VOV (sequence of): Troms	: Mac	roglob	ulin en	nia	
Exa	Sequentially if eny, leading	y list conditions, ng to immediate er Underlying eese or injury		Due	to (or es e con	sequence of):		0			
cal	Cause (Disc thet initieted resulting in	events	C	Due	to (or es e cons	sequenca of);					
an/Me			d							1	
Physicia	Pert II. Other	r significent condit	lons contributing to	death but n	ot resulting in the	underlying cause	given In Pert I.	23b. Dtd	d tobacco uee co	ontribute to	the cause of death?
by Physicia								10	Yes 2K No	3 □ Proi	bably 4 Unknown
by P								_	20110	00.10	out, valoui
ă									s en eutopsy	24b. W	ere autopsy tindings
Completed								per	formed?	CO	ailable prior to mpletion of cause
mp									,	of	death?
								1,0	Yes 2□No	10	☐ Yes 2☐ No
Be	25. Wes cas examine	se referred to medic						eeth (Check only	one)		
2	1 ☐ Yes		Hospital: 1X	Inpatient	2 ER/Outpe	ient 3 DOA	other: 4 Nursing	Home 5□ Res	sidenca 8 🗆 Oti	her (Specif	y)
Ë	27. Manner			e of Injury onth, Day Ye	28b. Time		ury et	28d. Describe	how Injury occu	rred	***
Certification:	1 Netu 2 Acc		tigation	man, Day 10	er) Injur		Yes 2 No				
Medical Certification:	3 ☐ Suid	olde 6 Could	I not be mined 28e. Place	ce of Injury	At home, ferm,	street, factory, offic	8		(Street end Num	ber or Rura	I Route Number,
T	4 🗆 Hor	nicide		ding, etc. (S				City or To	own, Stete)		
0	29a. Certifie	X Complete	ng Physiology To th	a best of m	. Ironidados de	ath account of the	Alma data a a data				NIL.
edical	(Check	only 2 Medica	ng Physician: To the Examinar: On the	Dasis of exe	minetion end/or	Investigation, in my	opinion, death oc	ce, and due to the curred at the time	e ceuse(s) end m e, date end pieca,	enner es si end due to	teted. the cause(s)
¥ e	one)		end me	nner steted							
	290. Signati	re end title of certifi	4.1	1	1		nse number	0	29d. Date signe	ed (Month,	Day, Year)
	▶ (mi	5/alhal	New	yu)	1	15 94	4	3-5	-	1 +
	30. Name ar	nd address of person	who completed cau	use of death	(item 23a) (Tyr	e, Print)					
0		topher Un			/	nsin Ave.	#208 Be	ethesda,	Md. 20)814	
State	31. Dete file	d (Month, Dey, Year				n-Mandell					
egistrar		MAR	0 7 1997	1100	na Davidso	n-Manage					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

hysiciar						ficate of			Reg. No.	21	UUC
nysiciai		1. Decedent's Nama (First, Middle, I ELLEN Kales		ישווע	TTIG			2. Date of De Month	Day	Year	3. Time of Dec
Medica xamine		4a. Facility Name (If not institution, g			1116		4b. City, Town, or		4c. Count	y of Death	2:55 P
Adminic		SPRING HOUSE NU					BETHESD			OMERY	
neral ector		579-60-7739	. Sex 7. A	nge (In yrs. Ia 82		onths Days	If Under 24 Hrs Hours Min	. (Month, Da		9. Birthol	aca (Stata or Fo
H		Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Locat	tion					Od. inside City Li
	010	Maryland Montgom	ery	Bethe	esda						1 □ Yas 🏖
a la	9	10e. Street and Number				10f. Zip Code			10g. Cltizen of	Whet Count	try?
	<u>a</u>	5233 Duvall Drive				20816			U.S.A.		
2	Dy rur	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedan Armed Forces 1 ☐ Yes 24 If Yes, Give Year or Dates:	?] No	if Ye	s Decedent of Hes, specify Cube	lispanic Origin? (S an, Mexicen, Puer Specify:	Specify Yas or No to Rican, etc.)		ce - Americe ick, Whita, a by: Wh1	atc.
t, the Medical Exp	mpleted	15. Decedent's (Specify only highest g	Education grade completed) College (1-4or		(Give kin	NOT use retired	during most of wa	rking	16b. Kind of B		ustry
		17. Father's Name (First, Middle, Las	st)		пошешан	ker	18 Mother's Na	me (First, Middle,	Own Ho		
To Re	Ď	William Robert	*				Alice (vialogii Sumai	110)	
To F	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing A	Address (Street	and Number or R	ural Boute Numb	er, City or Town	, State, Zip	Code)
er tra		Alice Huettig V	Wenger, Da	ughter	Thorn	Mountai	In Road,	Jackson	, NM. 0	3846	78.3
any injury or other tra anse.	2	20a. Method of Disposition 1 Burial 2XXCremation 3 4 Donation 5 Other (Special Control of the				on (Name of ory or other place ct Crema		Date 3/4/97	20c. Location	1	
any injury once.		21. Signature of Fineral Service Lice	ensee		J ^{22. N}	ame and Addre	ss of Facility	ns, Inc.			
	1	23a. Party Enlar the disease, or or heart failure. List	inplications that cause	d the death.			DC. 200		rrest,		Approximata Interval Betwee
clan lical iner		Immediata Cause (Final disease or condition	7m	1	, ,			1		1	Onsat and Deat
isit		resulting In deeth)	a	Due to (or a	as e consequer	7 C	1/m	phom	4-	C	Jmon
burial-transit			a		as e consequer as a consequer		Ifm	phom	4	C	2 mon
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State of Maryland / Department of Health and Mental Hygiene

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-	THE REAL PROPERTY.		Decedent's Name (First, Michael Control of the	idlo I ant)			Cel	uncate o	De	alli		0.0044.00	Reg. N	0.		0007		
1	Physic /Medi		व्यक्ताला	MAE H								2. Dete of De Month	ry 2	2,	1997	3. Tima of Death 7:30 PM		
1	Exami	ner	4a. Facility Nama (If not institu 10309 Pierce I	ion, give street Drive	end number)						ocation of Dee	- 1		ty of Deeth	y		
	Funeral Director		5. Social Sacurity Number 578-30-9834 Usual Residence of Decedent	6. Sex 1 ☐ M 2	7. A	ga (In yrs. last i 84	birthday) Yrs.	If Under 1 Year Months Day		Jnder: ours	24 Hrs. Min.	8. Data of Bi August 5	rth a <i>y,</i> 191	2	9. Birthi Cou Memph	place (Stete or Foreign ntry) LS, Ternessee		
	r the Maryland r 28a-1 show Jodified at	tor	10a. State 10b. Cour	gomery		10c. City, To	wn or Lo	cation Spring								10d. Inside City Limits 1 XYes 2 □ No		
	E 0 B	Funeral Director	10e. Street end Number 10309 Pierce	Orive				10f. Zip Code 209					-	Itizen o	Whet Cou	ntry?		
020	or Items	by	11. Marital Status 1 □ Never Merried 2 ☑ M 3 □ Widowed 4 □ Divorce	Ar arried 1 [es Decedant mad Forces Yas 2 Y Yas, Give eer or Detes:	?		Ves Decedant of Yes, specify Cu		nic Orig axican ecify:	gin? (Sp , Puarto	pecify Yas or N Rican, etc.)	0-	Spec	ace - Amari eck, Whita, ify: ucasi	atc.		
5-0	72 houn netural dical Ex	pete	15. Deced (Specify only high	ent's Education	nieted)	16	Se. Deced	lant's Usual Occ	upation	n most	of work	dna	16b.	-	Businass/In			
2121	within ans. than be Me	Completed	Eiamantery/Secondery (0-12) Co	oilege (1-4or 4	5+)		kind of work don DO NOT use reti DUSEWITE		y most	Or WOIN	Ming	Ov	vn H	ome			
Maryland 21215-0020	wild be filed Montal Hygi inted other affic event, I	To Be	17. Fether's Neme (First, Midd Harry	e, Last) Rives						Motha ari		e (First, Middle Die		n Sume	ime)			
	and 2 should walth and Mor 3.27 is marks ar traumatic		19e. Informent's Neme/Relation Nicholas V. 1					g Address (Stre Pierce								0901		
Baltimore,	mit. Pages 1 and autment of Health cortant: If Item 27 injury or other to		20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetio 4 ☐ Conetion /5 ☐ Other	n 3 □Ramov (Specify)	al from Stete	came	tery, crem	sition (Neme of netory or other p Universit				Date			- City or To			
Balt	permit. Pa Departmen Important: any injury once.		21 Signature of Faneral Salvio			0		Nama and Add						~ ^	0011			
r	100		225 Missouri Ave., NW, Washington and State of S										c or raspiratory arrast, Approximate Interval Between					
	Physician /Medical Examiner		Immediate Cause (Final disaasa or condition			RUSCL									1	Onset end Deeth		
		ner	resulting in deeth)	6		Due to (or es	s conseq	uence of):										
o,	executed an and riel-trans	Examiner	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying											1				
ox 68760,	certificate be executed nding physician and use as the buriel-transit	n/Medical	Ceuse (Disease or injury that initiated events resulting in deeth) Last	6		Dua to (or as a	consequ	uance of):							i			
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, P.O	= > %	by Physicia	Pert II. Other algnificant condi		ing to death t	out not resulting	j ini tries cur	idenying cause (Jiveii iii	ren i.				2□ No		o the cause of death? bably 4 ☐ Unknows		
Records,		Completed b										24e. Wes	en eut	opsy	av	ere sutopsy findings allable prior to empletion of cause desth?		
	ician: The law certificate has be rector, page 2 s		OF Means of and a self-									10		No		Yas 2 No		
N.		To Be	25. Wes casa referred to medicaxaminer?	Hospite	al: 1 ☐ Inpatio	ant 2 ER/0	Outnation	3□ DOA C	Mhon		of Deet	th (Check only		6 🗆 🗆	thar (Specia	6/1		
Division of Vital			27. Manner of Death	ling 28s	a. Dete of Inju (Month, Da		. Time of Injury	28c. Inj				28d. Describe				<i>y</i> /		
Divis	or Atter after dea Director d in by the	Certification:	3 Suicide 6 Could not be detarmined 28e. Piece of Injury - At home, ferm, streat, fectory, of building, etc. (Specify)									28f. Location City or To	Street a	ind Num te)	ber or Run	al Routa Number,		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	29e. Certifier (Check only one) 1 Certify 2 Medica	il Examiner: O	To the best in the besis o and menner st	f examinetion a	ge, death and/or inv	occurred at the estigetion, in my	time, de oplnio	ete and	l place, h occur	and due to the red et the time,	csuse(s) end n	nenner as s o, and due to	ststed. the cause(s)		
	To the To the comp	Me	29b. Signsture and title of certification	ier W	Ru	Www	D	29c, Lice D 3	315							Day, Year) , 1997		
	5' 7		30. Name and address of person Charles M. Ber						Si	lve	r Sr	oring.	MD	209	01			
	Sta Registr		31. Deta filed (Month, Dey, Yea MAR		32. Registr	Suna Dav	idson-	Mandall.								72.7		

State of Maryland / Department of Health and Mental Hygiene

					Certifica	te of	Death		Reg. No.	37 08	8286
Physicia	n	1. Decedent's Name (First, Middle, Le	est)					2. Data of D Month	eath Day	Year 3.1	Tima of Death
/Medic		DONALD JOSEPH						FEBRUA			7:25
Examin	er	4a. Facility Name (If not institution, give					4b. City, Town, o	r Location of Dea	th 4c. County	of Death	
		SAINT JOSEPH N		ENTER	u i littled		OWSON,			TIMORE	
Funeral Director			Sex 7. Age 1⊠M 2□F	60 (In yrs. lest bi	Yrs. Months	Days	If Under 24 Hi	n. (Month, E	24,1936	9. Birthplace (Country) Marvla	
show		10a. Stata 10b. County		10c. City, Tow	n or Location					10d. In	side City Lin
The second	tor	Maryland None	2	Bal	timore					1 (XYas 2□
or 28	lec ec	10e. Street and Number				ip Coda			10g. Citizan of	What Country?	
23a	<u>a</u>	9731 Red Clover (Court			2123	34		Unite	ed State	s
0 5	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Parmed Forces? 1 ☒ Yes 2 ☐ No lif Yes, Give Year or Dates: U	lo	13. Was Dace If Yes, sp		dispanic Orlgin? (an, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)	lo- 14. Rac Bla Specifi	ce - American Ind ck, White, etc. Y: White	dian,
"natural", edical Ex		15. Decedent's E			. Decedent's Us	ual Occur	pation		16b Kind of B	WIIITE	
n age	Completed	(Specify only highast gri Elementary/Secondery (0-12)	ade completed)		(Give kind of w life. DO NOT	ork done use retire	during most of w	orking	TOO. TAILS OF B	damasamiddan y	
2.4	E	10	College (1-4or 5		ruck Dri	ver			Fuel C	Company	
10 9	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middl	ame (First, Middle, Maiden Surneme)		
	ျှ	Francis Hauf					Hazel I	Bell			
S III		19a, Informant's Name/Relationship (Type, Print)	198	. Meiling Addres	s (Street	and Number or F	Ru <i>ral Rou</i> te Num	ber, City or Town,	vn, Stete, Zip Code)	
Department of the important: If them any injury or othe others.	Catherine L. Hauf	/Wife				er Court	Baltim	ore, Mar	yland 2	1234	
	20e. Method of Disposition 1 ☐ Buriai 2 ☒ Cremation 3 ☐	Removal from State	20b. Place o cemete	f Disposition (Ne ry, cremetory or	other ple	ce)	Data	20c. Location	- City or Town, Si	tata	
	4 □ Donation 5 □ Other (Special		Balt-V	vashingt	on C	remator	2-22-97	Laurel	. Marvl	and	
		21. Signature of Funaral Service Licer	nsee		22. Name a	nd Addre	ss of Facility				
		Stonber M	Loews	200					ome, Inc		0104
		23a. Pert1. Enter the disease, or com	plications that caused	the death. Do	not enter the mo	de of dvir	OLUMOLA ng. such as cardi	PIKE EI	licott C	Appro	oximata
		shock, or heart failure. List only	one cause on each lin	Θ.			79, 00011 00 001011	20 or 100pirulory	-11001,	Intan	vai Between
ysician /ledical		Immediate Cause (Final	MEM's CM	AMTO N	OM OM	T.T.	ODTT				
aminer		disaase or condition rasulting in death)	e. PETAST	ATIC N	ION-SMA	ا بلیك	CELL LU	ING CAN	CER	6 WI	EEKS
	ner		RESPIR		FAILUR						
	Examiner	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or Injury that leithed experts.	CARDIO		consequence of		EST	-	, qui		
physici as the bu	Medical	Causa (Disease or Injury that Initiated events resulting In daath) Last	c	Dua to (or as a	consequence of)	:					
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d for	Physician	Part II. Other significant conditions of	ontributing to death bu	t not regulting i	n the underlying	cause ah	ran la Bart I	22h Die	i tobacco use co	intelligita to the c	auga of dea
ed by the detached	nys	Facts. Other significant conditions o	ontributing to death bu	t not rasulting i	n tha undariying	cause giv	an in Part I.		Yes 2 No		
a det	by P								1 Yes 2 No	3 Probably	4 Unkn
								24a. Wa	s an autopsy	24b. Were au	topsy finding
shee	Completed							pen	formed?	available complete of death?	on of cause
ate has	Ë							40	Vac de la		
certificate rector, pag		25. Wes case referred to medical							Yes 2 No	1 🗆 Yes	2 No
is certific director,	D	examiner?	Hospital: 🚾			Oth Oth	or.	eath (Check only		- 12.43	
5 70 1	0	1 Yes 2 No 27. Menner of Deeth	142 Inpatier			UA	4 Li Nursing	_	idence 6 Oth		
Aftar	0	1 Natural 5 Pending	28a. Date of Injury (Month, Dey	Year) 280.		28c. Injur Wor		28d. Describe	how Injury occur	red	
the the	Car	2 ☐ Accident investigation			М		Yes 2 □ No				
Director: Aftar t d in by the funera	Certification:								(Street end Numb own, Stete)	er or Rurel Rout	e Num <i>ber</i> ,
6 0		29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowledge	, deeth occurred	at the tin	ne, date and place	e, and due to the	cause(s) and ma	anner as stated.	
- Fu	edical	(Check only 2 Medical Exam	niner: On the besis of and manner stat	examination an	d/or investigation	, In my o	pinion, death occ	urred at the time	, date and placa,	and due to tha ca	ausa(s)
To the		29b. Signature ergif litle of certifier	0		29	c. Licans	a number		29d. Date signe	d (Month, Day, Y	'ear)
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			completed cause of de							3	
		GEORGE WEINE	R, M.D.	9512 H	ARFORD	ROA	AD, BALT	IMORE,	MARYLAN	ID 2123	4
State	-	31. Date filed (Month, Day, Yeer)	32. Registra	s Signature	Carl 11						
Registra	'	FEB 2 4 1	131 Janes	V TURNING T	AND STATE OF THE PARTY OF THE P						
16 Rev 6/95											

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Marylance Department of Health and Mental Hygiene Certificate of Death 1. Qecedent's Name (First, Middle, Last) 2. Dete of Death Month UTWENDOLYN Ebrusky 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Fallston General Hospital Fallston Harford If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 2 N F Yrs. 213-03-7544 77 Nov. 6, 1919 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Harford Bel Air 1⊠ Yes 2□ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Sunflower Drive 21014 USA 11. Meritei Stetus 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Race - American Indien, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 M Married 1 ☐ Yes 2 ☑ No Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Book Keeper Retail 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) George L. Stabler Margaret I. Loats 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Sharon A. Daugherty, Daughter 2889 Brightside Drive, Manchester, Maryland 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/3/97 Woodlawn Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Eachity Howard K. McComas III Funeral Home, P.A. 50 West Broadway Street, Bel Air, Maryland 21014 Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart taken. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) MyDCW dia Due to (or as a consequence of): Due to (or es a consequence of)

Physician /Medicai Examiner

physician s the burial

The law requires that the death certificate be axecuted

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completally filled in by the funeral director, to

Division of Vital Records, P.O. Box 68760,

Department o Important: If any injury or

Physician

/Medical

Examiner

10a. State

Funeral

Director

items 23s or 28s-f show

Director

Completed by Funeral

Be

nit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland artiment of Health and Mental Hygiene. ortant: if item 27 is marked other than "natural", or items 23s or 28sd show injury or other trainmatic event, in Medical Entires and the notified at

Baltimore, Maryland 21215-0020

Examiner

D47463 February 27, 1997

Print)
Rock Spring Rd Forest Hill Md 21050

Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlying	ceuse given In Part I.	23b. Did tobacco use co	ontribute to the cause of death? 3 Probably 4 Unknown
				24e. Wes en eutopsy performed?	24b. Were autopsy findings evalleble prior to completion of cause of death?
25. Was case referred to medicel examiner?	Hospital: V.		Other	Death (Check only one)	
1 Yes 2 No 27 Manner of Death Natural 5 Pending 2 Accident Investigetion	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	9 Home 5 ☐ Residence 8 ☐ Ot 28d. Describe how Injury occu	her (Specify) rred
3 Sulcide 6 Could not b 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, facto	ory, office	28f. Location (Street and Num City or Town, Stete)	ber or Rural Route Number,
29a. Certifiler (Check only one) Certifying Ph	yefclan: To the best of my known ther: On the basis of exemine and manner stated.	owledge, death occurre etion end/or investigation	d et the time, date and pla on, in my opinion, deeth oc	ice, and due to the cause(s) end m courred at the time, date and plece	nenner as stated. , and due to the ceuse(s)
29b. Signature and title of certifier	1	2	9c. License number	29d. Date sign	ed (Month, Day, Year)

State Registrar

and address of person who completed ceuse of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

08282

-						Cert	ilicale c	ט ונ	eaui			Reg. No.			
-	Physic	an	1. Decedent's Name (First, Middla, Las.	•							2. Data of De Month	Day	Year	3. Tima of De	ath
	/Medi		Ronald Sco	-	ynie						March			4:00P	M
.	Examir	ner	4a. Facility Name (If not institution, giva)						cation of Deat	111111111111111111111111111111111111111			
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п	Funeral		5. Social Sacurity Number 6. Se	X 7. Ag X M 2□ F	ga (In yrs. las	Yrs.	Months Da		Hours	Min.	(Month, De	th ay, Year)	9. Birtho	place (Stata or Fo ntry) V York	oreign
	Director		231 17 7605 Usual Rasidence of Dacedant		31						July 31	, 1965	Nev	York	
	ahow		10a. Stata 10b. County		10c. City,	Town or Loca	ation						1	Od. Inside City L	imits
	Man	to	Maryland Charle	S	Brva	ns Roa	ad							1 □ Yes 2	No.
	r 284	rec	10e. Street and Number		,		10f. Zlp Cod	le				10g. Citizan of	What Cour	ntry?	
	h wit	ai D	6636 Bucknell Roa	d			206	616				U.S.A			
	ours after death with the Maryla "at", or Neme 23s or 28s-f shor Examiner must be notified at	by Funeral Director	11. Marital Status	12. Was Decedanf Armed Forçeş?	Evar in U,S.	13. W				gln? (Spe	ecify Yas or No Rican, etc.)		e - Amaric	can indian,	
0	or he	F	1 ☐ Nevar Marriad 2 🕅 Married	1 ☐ Yas 2(X)	No		Tes, specily C □Yes 2 🛣 1				Hican, etc.)		ck, Whita,		
00	ours Frail.	1 by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		''	_ 1 es _ 2 (2).1	40	Specify.			Specif	Whi	Lte	
Baltimore, Maryland 21215-0020	be filed within 72 hours after death with the Maryland flat Hyglene. d other than "natural", or flems 23s or 28s-f show event, tra Medical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highast grad	ication la completad)		16a. Deceda (Giva k	nt's Usual Oc hd of work do O NOT usa rai	cupati na du	ion ring mos	t of worki	ing	16b. Kind of B	usiness/In	dustry	
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anc	of la b	Be						1				, Maldan Sumar	na)		
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Ma	s 1 and 2 should f Health and Men flem 27 le marke other traumatic		19e. Informant's Name/Relationship (T)									er, City or Town			
o,	Heall Heall Her		Wanda Lee Haynie 20a. Mathod of Disposition	- Wile	20b. Plac	of Disposi	BUCKNO tion /Nama of	, 611	Roa	a, B	ryans l	Road, MI			
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五	rtant riury		4 Donation 5 Other (Spacify)				d Ceme		-		/5/97			Virgini	a
Ba	permit. Pages 1 an Department of Heal Important: if Item 2 any Injury or other once.		21. Signature of Funeral Service Licens	101		22.	Name and Ad Arehar	t-F	cho1	y s Fii	neral I	Home. In	iC.		
			23a. Part 1. Enter the disease, or compishock, or heart failura. List only o	cho Z	moog	45	P. O.	Box	567	, La	Plata,	Marylar	d 200	546	
	B. T		shock, or heart failura. List only o	na cause on each li	ne.	Do not enter	the mode of t	ayıng,	such as	cardiac c	or respiretory a	rrest,		Approximata Interval Betwee Onsat and Deat	
	Physician /Medical													1	
7	Examiner		disaasa or condition rasulting in death)	ghish	it U	now lis	TO Th	70	nea	4				nstantanx	DVS
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ó	exec an an rial-tr	EX	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated evants		200 10 (01 2	5 ta 501.00qu	21100 017.						1		
68760,	certificate be executed Iding physician and Ise as the bunal-transi	n/Medical	Cause (Disease or injury that initiated evants resulting in death) Last	C	Dua fo (or as	s a conseque	ance of):								
39	n certifica anding ph use as ti	Med	lasuring in oddin) cast		·								į		
Sox		an		d									1		
). B	The law requires that the death ate been signed by the atterpage 2 should be detached for a	Physicia	Part II. Other significant conditions con	ntributing to death b	ut not resultin	ng in tha und	lerlying causa	given	in Part I		23b. Did	tobacco use co	ntribute to	the cause of de	eath?
P.0	d by t	Phy									10	Yes 2□ No	3 Pro	bably Munk	known
	es that igned to be det	Ď											1		
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ec	law lasb	npie											of	mpletion of causi death?	a
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/ita	Physician: r this certificated director,	Be	25. Was case referred to medical examiner?					2	26. Place	of Death	(Check only	ona)			
5	Physic this ce	2	12 Yas 2□ No	fospital: 1 🔲 Inpatle	enf 2 ER	VOutpatient	3□ DOA	Other:	4□ Nu	rsing Ho	ma 5 Resi	dence 6 □Oth	er (Specif	у)	
П	aling Ph h. After thi funeral		27. Mannar of Death 1 □ Natural 5 □ Pending	28a. Data of Inju (Month, Day	y Year) 28	Bb. Tima of Injury	28c. Ir	njury a Nork?	ıt		28d. Dascribe	how Injury occur	red		
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Division	er der de	Ħ	3 Suicide 6 Could not be datarmined	28a. Place of inju- building, etc	ury - At home	e, farm, stree	it, factory, offi	Ce .			28f. Location (Street and Numl	oer or Rura	al Routa Number,	,
	ta safe of the color of the col	Ce		hane	(a pr				
	To the Hospital or Attend within 24 hours after death To the Funerel Director:. completely filled in by the	edicai Certification:	29a. Certifier (Check only 1☐ Certifying Physical Exami	sician: To the best of	of my knowle	dga, death o	occurred at the	e time,	, date an	d place, a	and due to the	cause(s) and m	anner as s	lated.	
	the Print 24 the Print Plet		one)	and manner sta	ated.	Tuna or invo					od at the time,				
	P A P P P P P P P P P P P P P P P P P P	Σ	29b. Signature and title of certifier	\	1	٨ .	29c. Lice	ense n	number			29d. Data signe	d (Month,	Day, Year)	
			ANYTHING	m/10 (0)	Mr-tz	ME.		1.	399)		2 March	297		
			30. Neme and address of person who co	empleted cause of d	leath (Item 23	3a) (Type, P	rint)	2	1-	1					
				0x 16A7	Wo	1/2/1	- WA	6	060	4					
	Sta	_	31. Date filed (Month, Day, Year) MAR 1 1 19		ar's Signatur	0									
	Registr	al	mar 1 1 19	97 Juli	a do Ruels	ion Rand	all								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			otate of Maryland /	Certificate of L		, ,	1. No. 97	08283												
ı	Physic	an	Decedent's Neme (First, Middle, Last) GEORGE FRANK HOWSER			2. Dete of Deeth Month	Ž8, 199	3. Time of Death												
	/Medi Examir		4e. Facility Neme (If not Institution, give street end number) 5521 Lanham Station Road		lb. City, Town, or Loc Lanham	cation of Death	4c. County of De	eeth												
	Funeral Director		5. Social Security Number 216-44-4491 6. Sex 216-44-4491 7. Aga (In yrs. lest b	Prince Georges 9. Birthplace (State or Foreign Country) 1907 Lanham, MD																
	r 28a-f show	tor	Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, To- Maryland Prince Georges Lanh	wn or Location		,		10d. Insida City Limits 1 ☑ Yes 2 ☐ No												
	th with the 23a or 28a	Funeral Director	10e. Street and Number 5521 Lanham Station Road	10f. Zip Code 20706			Citizen of What	Country?												
020	or Items	þ	11. Merital Status 1 Never Married 2 Merried 3 Midowed 4 Divorced 12. Was Decedant Ever in U,S. Armed Forcas? 1 Yes 2 Mo If Yes, Give Yeer or Detes:	13. Was Decedent of Hi If Yas, specify Cube 1 ☐ Yas 2 ☒ No		cify Yas or No- Rican, atc.)	14. Race - Ar Biack, W Specify: White													
21215-0020	filed within 72 hours Hyglena. ither than "natural", ent, the Madical Ex	Be Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 12 15. Decedent's Education (Specify only highest grade completed) 16. Specify only highest grade completed)	a. Decedent's Usuei Occupa (Giva kind of work done of life. DO NOT use retired, civil Enginee)	ation during most of workin f) T	. Kind of Business/Industry terstate Commerce Commission														
Maryland 2	s 1 and 2 should be filled f Health and Mental Hygis fem 27 la marked other other traumatic event, it	To Be C	17. Fathar's Name (First, Middle, Last) John W. Howser		18. Mother's Neme	(First, Middle, Me														
	and 2 sho saith and 1 27 is ma		Jdn P. Howser-Son 25	b. Meiling Address (Street & Bay Drive, Anna	apolis, MD	Route Number, 0 21403	City or Town, State	a, Zip Code)												
Baltimore,	permit. Pages 1 and 2 Department of Health s Important: If them 27 is any Injury or other tra once.		20e. Method of Disposition 1	of Disposition (Name of ary, cremetory or other piece Lincoln Cemet	tery 3/		oc. Location - City Brentwood													
Bal	Depart Import any In		21. Signature of Funeral Service Licentee	22. Nama and Addres Rendon/Hale 9013 Annap	e Funeral olis Road			706												
	Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting in deeth) Due to (or es a consequence of):																		
x 68760,	that the death certificate be associted ed by the attending physician and detached for use as the buriel-transit	Completed by Physician/Medical Examiner	Completed by Physician/M	Completed by Physician/M	if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury c	consequence of):														
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cords,	requires					Completed	pieted by	pieted by	pieted by			24e. Wes an	eutopsy 24	b. Were eutopsy findings available prior to completion of causa of death?						
Division of Vital Records,	ding Physician: Tha law h. h. Aftar this cartificata has b funaral director, paga 2 s						25. Wes case referred to medical			1 ☐ Yes	2× No	1 Yes 2 No								
	Physician: this cartific ral director,	To Be	examiner? 1 Yes 2 No Hospitel: 1 inpatient 2 ER/C	Outpatient 3 DOA Othe	28. Piace of Deeth er: 4 ☐ Nursing Hom	-	ce 8 ☐Other (S	pecify)												
	Attanding Ph r death. ector: Affar th by the funaral		Certification:													2 ☐ Accident		k? Yes 2 □ No	8d. Describe how	
ă	To the Hospital or Attanding F within 24 hours aftar death. To the Funerel Director; Attar complataly filled in by the funar		building, etc. (Specify) 29e. Certifier Sertifying Physician: To the best of my knowledge	e, deeth occurred at the tim	ne, dete end piece, e	City or Town,	se(s) and menner	as stated.												
	within 24 within 24 To the Fi	Medical	(Check only one) Madical Examiner: On the basis of examinetion e end menner steted.	29c. Licanse																
	1 × 0 0		1 / Lung mo	D37	1251		I. Data signed (Mo													
(10)		30 Name and address of person who completed cause of deeth (item 23a) Falls III (Mark Day Your)		Apoin on	e, u	Arbon 1	97 -m 2706												
	Sta Registr		31. Dete filed (Month, Dey, Year) MAR 03 1997	while																

DHMH 16 Ray 6/95

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State of Maryland / Department of Health and Mental Hygiene 08284 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death **Physician** February 1 4:06 AM William HIGHTOWER Irvina /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Lanham Prince Georges Doctors Community Hospital If Under 1 Year | If Under 24 Hrs. 8. Data of Birth 3 (Month, Osty Year) 9. Birthplace (State or Foreign WASHTNGTON, DC 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 1 D_xM 2 □ F 578-38-6768 66 Yrs Director Usual Residence of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits the Marvar 25a-f show notified at XX Yas 2 No Director P/G MITCHELLVILLE MD 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? ò he Medical Examiner must be 11406 WAESCHE DRIVE 20721 USA "natural", or Items 23s Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 14⊒ Yes 2 □ No If Yas, Giva Yaar or Datas.ARMY Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1□ Yas 2□ No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry al Hygiene. I other than "n **EDUCATION** Elamantary/Secondary (0-12) I2 YEARS 11 YEARS DOCTOR OF EDCUCATION (PHD) Department of Health and Alertal Hy Important: If Health and Mertal Hy Important: If Health 27 is marked other any injury or other 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) To UNKNOWN WILLIAM IRVING HIGHTOWER SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) SAME AS 10A,B,C,D,E,&F MARGARET HIGHTOWER 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burlal 2 □ Cramation 3 □ Ramoval from State LINCOLN MEMORIAL CEMETERY 3/4/97 | SUITLAND, MD. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Facility JOHN T. RHINES CO., INC. 21. Signeture of Funaral Sarvice Licenses 3030 12TH ST NE, DC 20017 23a. Part 1. Entar the diseasa, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart tailura. List only one ceusa on each line. Approximate Interval Between Onsat and Death Physician archiogenic /Medical Immediata Causa (Final disaasa or condition rasulting In daath) Examiner Dua to (or as a consequence of) Examiner burial-transit Sequantially list conditions, if any, laading to immadiata ceuse. Enter Underlying Causa (Disaase or Injury that initiated events rasulting in daath) Last and Dua to (or as a consequence of): certificate be execu Box 68760. physician Physician/Medicai the Dua to (or as a consequence of) 98 esn P.0. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records, by 99 24b. Wara autopsy tindings available prior to complation of cause ot deeth? 24a. Was an autopsy Completed performed? page 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No The Hospital or Attending Physician: "
when 24 hours after death.

To the Funeral Director: After this certifica 25. Wes cesa ratarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 27. Mannar of Deeth 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Netural 2 Accidant 5 Pending after death.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28t. Location (Streat and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, tarm, streat, tactory, office building, atc. (Specify) 4 Homicide 29a. Certifier 1x Cartifying Phyalcian: To tha best of my knowledge, death occurred at the time, date end place, and due to tha ceuse(s) and menner as stated.

2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and mannar stated 29b. Signatura and title of cartifier 29c. Licansa number 29d. Date signed (Month, Day, Year) 3346 3(27/97 who completed cause of deeth (Item 23e) (Type, Print)

State Registrar 31. Data tiled (Month, Day, Year) MAR 03 1997 Handen Verth was

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State of Maryland / Department of Health and Mental Hygiene 08285 Certificate of Death 1. Decedant's Nama (First, Middia, Last) 2. Data of Death 3. Tima of Death **Physician** 2926/97 Day 7:05 AM HARRIS DORA /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MONTGOMERY SILVER SPRING HOLY CROSS HOSPITAL 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** 1□M 2\ F Days Hours 86 Yrs. 579-52-3843 **Director** PITTSBURGH, PA. 3/6/10 Usual Rasidanca of Decedan r 28a-f show a notified at 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits WASHINGTON N/A DC 1 Nas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? th and Mental Hygiene. 7 Is merked other than "natural", or items 23a or treurwite event, the Medical Examiner must be n 20011 USA 432 RIGGS ROAD NE Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedant Evar in U,S. Armad Forcas? Raca - American Indian, Black, White, atc. 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yas 2 ☐ No If Yas, Giva X Yaar or Datas: 1 Yas 2 No Specify: Specify: BLACK þ 3 ₩ Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Dacedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mertal Hygene. Important: If hear 27 is marked other than 1 any Injury or other treasurants awant the Many Eiamantary/Secondary (0-12) Collage (1-4or 5+) NONE NONE HOUSEWIFE 9TH GRADE 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nema (First, Middla, Maiden Surnama) LAURA BURTON JUNIUS BURCHETT 19b. Meiling Address (Streat and Number or Rural Routa Number, City or Town, State, Zip Code) SAME AS 10A,B,C,D,E,&F 19a. Informent's Neme/Ralationship (Type, Print) 9 VIRGINIA HUISWOUD 20b Place of Disposition (Name of State Place) 20a. Mathod of Disposition 20 ARREN COUNT Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Spacify) DREWRY, NC Burchetts Chapel Church Cem. 3/6/97 21. Signatura of Funeral Sarvice Licanses 22. Nama and Addrass of Facility JOHN T. RHINES CO., INC. 3030 12TH ST NE, DC 20017 For the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, frame failure. List only one cause on each line. Approximata Interval Between Onsat and Deeth **Physician** /Medical tmmediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and the burial-transit Sequantially list conditions, if any, laading to Immadiata cause. Entar Undarlying Ceuse (Disaase or Injury that initiated avants rasulting In death) Last Dua to (or as a consequence of) Physician/Medical Dua to (or as a consequence of): attending pl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by it 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE þ 24b. Wara autopsy findings available prior to completion of cause of death? should 24a. Was an autopsy parformed? Completed ATRIAL FIBRILLATIONI 2 12 No 1 Yas 2 No STROKE or Attending Physician: after death. Director: After this certifice 25. Was casa rafarred to medical axaminar?
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Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Homa 5 Residence 8 Other (Specify)

27. Mangar of Death 1 DNatural

4 Homicida

5 Panding 2 Accident 3 Sulcida

Invastigation 6 Could not be datarmined 28a. Data of Injury (Month, Dey Year) 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28b. Tima of

28d. Describe how Injury occurred 1 Yas 2 No

28f. Location (Streat and Number or Rural Route Number, City or Town, Stata)

29a. Certifiar (Check only one)

1 🖺 Certifying Physician: To tha best of my knowledga, daath occurred at the tima, deta and place, and dua to tha cause(s) and menner as steted. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

29b. Signature and title of control

29c. Licensa number

29d. Data signed (Month, Day, Year)

20910

D 50106

30. Nama and audrass of person who completed causa of death (Itam 23a) (Type, Print)

TACKSON 31. Data filed (Month, Dey, Year)

FOREST GLEN RD., SILVER SFRING 22. Registrer's Signeture MAR 03 199

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State Registrar

funeral

Certification:

Medical

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

W 10 40

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08286 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Deeth Day Yaar Bertha Louise Hardesty 1997 March 8:25 A.M. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Fort Washington Hospital Prince George's 7. Age (In yrs. last birthday) If Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 X F 579-20-7212 Yrs. Dec. 20, 1902 Washington, D.C. Usuai Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Oxon Hill 1 ☐ Yas 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 1203 Stratwood Avenue 20745 U.S.A. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Biack, White, atc. 1 Never Married 2 Married If Yes, Give Yaar or Dates: 1 ☐ Yes 2 No Specity: Specify: White 3 Vidowed 4 □ Divorced 15. Decedant's Education 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) George Mathieson Lucian Dent 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Pearl L. Cooksey/Daughter 1203 Stratwood Ave. Oxon Hill, Md. 20745 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Cedar Hill Cemetery 1 XBurial 2 Cremation 3 Removal from State 3/7/97 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signal of Funnyal Service Licensee 22 Nama and Address of Facility George P. Kalas Funeral Home als 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 and . Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cerdiac or raspiratory arrest, by, or heart failure. List only ona cause on each line. Approximata Interval Between Onset and Deeth Immediate Cause (Finel disaase or condition resulting In death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): ier significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use coptributs to the cause of death? 1 Yes 2 196 3 Probably 4 Unknown 4b. Wera autopsy findings available prior to 24a. Was an autopsy performed? completion of ceusa of death? 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medica examiner? 26. Piace of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3DOA 27. Manner of Death 1 2 Natural 28c. Injury at Work? 28a. Dete of Injury (Month, Day Year) 28d. Dascribe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide

Examiner Physician/Medical Examiner attending physician and for use as the burial-transit requires that the death certificate be executed P.O. Box 68760. Records. Completed The law Vital Division of 2 Affler or Attending after death.

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Certification: To

Medical

4 Homicide

29a. Certified

Physician

/Medical

Examiner

Funeral

Director

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Hygiene.

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Department of Health and Mantal Hy
Important: if Nem 27 is marked oth any injury or other traumatic event applie.

Physician /Medical

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Certifying Physici Medical Examined ovae) 29b. Signature ay

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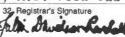
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Date signed (Month, Day, Year)

30. Jame and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Levine, M.D. 7801 Old Branch Ave. #409, Clinton, Md. 20735 31. Date filed (Month, Day, Year)

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08288 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ROGER HARMON Month W 4:20 PM 3 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth SPRING MONTGOMERY NURSING SANDY FRIENDS HOME 8. Date of Birth (Month, Dey, Year) Feb. 10,1925 If Under 24 Hrs. If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthdey) 9. Birthpiace (State or Foreign Months Days Hours 1⊠M 2□ F Country) Maine Yrs 72 006 18 7348 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits X2 Yes 2 No Hyattsville Maryland Prince George's 10a. Streat and Number 10f. Zip Code 10g. Citizen of What Country? 5001 70th Place 20784 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 14. Race - American Indien, Black. White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2KMarried 1 Yes 2 No Specify: White 3 Widowed 4 Divorced 43-46 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Retail Food 12 Meat Manager 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Albert Harmon Diana St Onge 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred C. Harmon 5001 70th Place Hyattsville Md. 20784 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from Stete 20c. Location - City or Town, State Moreland Family Cemetery 3/8/97 Gorman Maryland 4 □ Donation 5 □ Other (Specify) of Funeral Service Licenses Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximata Intervei Between Onset end Death Immediate Cause (Final disease or condition resulting in death) a HYDRCEPHALUS Due to (or as a consequence ot): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case reterred to medical 26. Place of Death (Check only one)

The law requires that the death certificate be executed physician and s the buriel-transit Division of Vital Records, P.O. Box 68760, 88 the signed by peed has certificate or Attending Physician: After this death. Director:

Physician

/Medical

Examiner

Funeral

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Directo

Funeral

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Certification: To

Medical

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72 hours after

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int. If flow 27 is merked other than "

Department of Health reportant: If Item 27

Physician

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Examiner

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examiner? 1 ☐ Yes 251 No	Ho	ospital:	3 🗆 1	DOA Other: 4	Mursing H	Home 5 ☐ Residenca 6 ☐ Other (Specify)			
Z LI ACCIDENT	ding stigation	28a. Date of injury (Month, Day Year)	jury 28b. Time of		28c. injury at Work? 1 Yes 2 No		28d. Describe how injury occurred		
3 ☐ Suicide 6 ☐ Coui 4 ☐ Homicide dete	id not be rmined	28e. Piace of injury - At he building, etc. (Specification)	ome, farm, stree by)	t, fect	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
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(Check only one)

2 Medical Examiner: On the basis of tray knowledge, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29b. Signature end title of cartifier

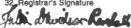
29d. Dete signed (Month, Dev. Year) 25345

30. Name and address of person who completed cause of death) (item 23a) (Type, Print)

ST. SILVER SPRING, MA 20905 E. GLANLY LLOVER LY 4401 733 31. Date tiled (Month, Day, Year) 32 Registrar's Signature

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1997^{Yeer} Day 13, MARCH HOSKINS 4b. City, Town, or Location of Deeth 4c. County of Deeth MONTGOMERY ROCKVILLE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 1 ☐ M 2 🕱 F Days Hours Yrs. 1910 87

1. Decedent's Name (First, Middle, Last) **Physician** 00:35 AM /Medical 4e. Facility Name (If not institution, give street and number) **Examiner** SHADY GROVE ADVENTIST HOSPITAL 5. Social Security Number 9. Birthplace (State or Foreign Funeral WEST VA. Director 418 05 6107 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ne 22a or 28a-f show must be notified at MARYLAND MONTGOMERY DAMASCUS Director 1 ☐ Yes 2 KNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20872 11 VALLEY PARK COURT Items 23a UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Bleck, White, etc. 11 Merital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 8 WHITE 1 ☐ Yes 2 No Specify: g Specify 3 Widowed 4 Divorced "natural". Completed 15. Decadent's Education (Specify only highest grade com, 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **INSURANCE** SECRETARY nut. Pages 1 and 2 should be illed artment of Health and Mertal Hygi ortant: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DAVID MARY A. CLAYTON Μ. ALLEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MICHELE L. ROLLENCE, GRANDDAUGHTER 11 VALLEY PARK COURT, DAMASCUS, MD. 20872 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremetion 3 ☐ Removal from State METROPOLITAN CREMATORY 3/14/97 ALEXANDRIA, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licansee MURTEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final CONCRESTIVE YEARS HEART FAILURE diseese or condition resulting in death) Examiner Due to (or as e consequenca of): CEREBROVASCULAR ACCIDENT ettending physician and for use es the bunish-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) ANEMIA YEARS Records, P.O. Box 68760. Physician/Medicai Due to (or as a consequence of): CARDIOMYOPATHY YEARS Part II. Other significant conditions contributing to death but not resulting In the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Š 99 been sig 24b. Were autopsy findings evailable prior to Completed 24a. Was an autopsy completion of cause of death? page 2 1 ☐ Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural

Medical Certification: 2 Accident 3 Suicide

5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of cartifier

29d. Date signed (Month, Day, Year) MARCH 13, 1997 D-40201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARZAD ASSAR

1502

MAIN ST. MT AIRY, MD

State Registrar 31. Date filed (Month, Day, Year) MAR 1 9 1997

32 Registrer's Signeture in variason

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physici /Medi Examir	cal	1. Decadent's Name (ERT	#.	JOH nber)	NSO	N, J	4b. City. Town	2. Date of E	H 2	Sunty of De	3. Time of Death 97 0540
Examin	ier		GROVE A			PITAI		ROCKV				GOMERY
Funeral Director		5. Social Security N 212-12- Usual Residence o	7319	Sex 1⊠M 2□F	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Ye Months Da	ear If Under 24		Birth		Birthplace (State or Foreign Country) Maryland
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Herra 23e or 28e-f show there must be notified at	Funeral Director	10e. Street and Nu 5120 E	mber Brookevi	ille Ro	ad, Bo	x 274	10f. Zip Cod 208				en of Whet	Country?
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as been sign a 2 should be	npleted b								24a. Wa	s an autops formed?	y 24b	were autopsy findings available prior to completion of ceuse of death?

Division of Vital F To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, it

Medical Certification: To Be

25. Was cese referred to medicel examinar? 1 Yes

27. Mannar of Death 1 Natural 5 Pending investigation

2 Accident 3 Suicide 6 Could not be determined 4 Homicide

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

26. Placa of Death (Check only one)

1 Yes

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) To Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated.

28c. injury at Work?

1 Yes

29b. Signetury

D21243

1 ☐ Yes 2 ☐ No

PRINCE PHILLIP DR, #104, OLNEY, MD 2083Z NEWSOME 31. Date filed (Month, Day, Year)

State Registrar MAR 0 5 1997

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadent's Name (First, Middle, Last) 2. Data of Death **Physician** Month Year Anne V. Johnson February 28, 1997 9:57 AM /Medical 4a. Facility Nama (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Westchester Park Dr. Apt. 610 College Park Prince George's 5. Social Sacurity Number If Undar 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** 1 □ M 200 F Yrs. Director 227-30-7563 80 JAN. 5, 1917 VIRGINIA 10a Stata 10h County 10c. City. Town or Location 10d. Insida City Limits 28a-f show Expression rount be notified at 1 X Yas 2 □ No Director MD. PRINCE GEORGES COLLEGE PARK 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? ò items 23a 6200 WESTCHESTER PARK DR. #610 U.S.A. 20740 Funeral 12. Was Dacadent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 Ø No If Yas, Giva Yaar or Dates: 13. Was Decadent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Raca - American Indian, Black, White, atc. Illed within 72 hours efter 1 X Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yas 2 X No Spacify: by Specify. 3 ☐ Widowed 4 ☐ Divorcad WHITE Completed the Medical 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decadant's Education 16b. Kind of Business/Industry (Specify only highast grade completed) nd Mental Hygiene. marked other than Elamantary/Secondary (0-12) Collage (1-4or 5+) DEP'T. OF HIGHWAYS SECRETARY 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middia, Maldan Sumama) 2 should be fi and Mental H Be JOHN HERVEY **JOHNSON** ANN ELIZA 19e. Informant'a Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) mportant: If Item 27 is ROLAND L. VanALLEN/BROTHER-IN-LAW TUCKERMAN ST., SEABROOK, MD. 20706 9112 20b. Place of Disposition (Nama of comatary, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 🌠 Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) CHAMBERS CREMATORY 3/4 RIVERDALE, MD. 21. Signature of Funeral Service Licental 22. Nama end Address of Fecility M00091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Intervel Batwaan Onsat and Deeth **Physiclan** /Medical Immediate Causa (Final mm disaasa or condition rasuiting in daath) Examiner Examiner The law requires that the death certificeta be executed Sequantielly list conditions, if any, laeding to immadiata causa. Enter Underlying Ceusa (Disaase or Injury that initiated avants rasulting in death) Last and physician s the burial Box 68760. Physician/Medicai Dua to (or as a consequence of): P.O. I signed by the a ificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably Ladi Records, þ 24b. Wera autopsy findings svellebla prior to Completed 24a. Wes en eutopsy completion of cause of death? page 2 1 Yas 2 XNo 1 ☐ Yas 2 ☐ No this certificate Vital or Attending Physician: Be 25. Was casa refarred to medical axaminar?

107 Yas 2□ No 26. Place of Deeth (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To of 27. Mannar of Death 28e. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred After Division Naturel 5 Panding invastigation s efter des. 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarminad 3 ☐ Suicida 28f. Location (Straet and Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - At homa, farm, street, factory, offica building, etc. (Spacify) 4 | Homicide within 24 hours e To the Funeral C complataly filled the Hospital 29a. Cartifiar Certifying Physicien: To the best of my knowledge, death occurred at the time, dete and place, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the causa(s) and manner stated. Medicai (Check only one) 29b. Signature and title of cently 29c. Ligense number 29d. Date signed (Montle Day, Year) 30. Nama and address of person who completed cause of death (Itam 23a) (Typa, Print) Queens ben 32. Rogistrar's Sign State Registrar

Mary Mary State St 1 2 7 N F . D . The state of the s and a second of the form of the case Managament in terms. . 12 1 The Park 1 1 2 The Park 1 Symples - that problem would treat to be book totally by the

UNK. 97-058 97-1206-015 wlc

> **Physic** /Medi Exami

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Maryland Department of Heelth and Mental Hyglane. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit

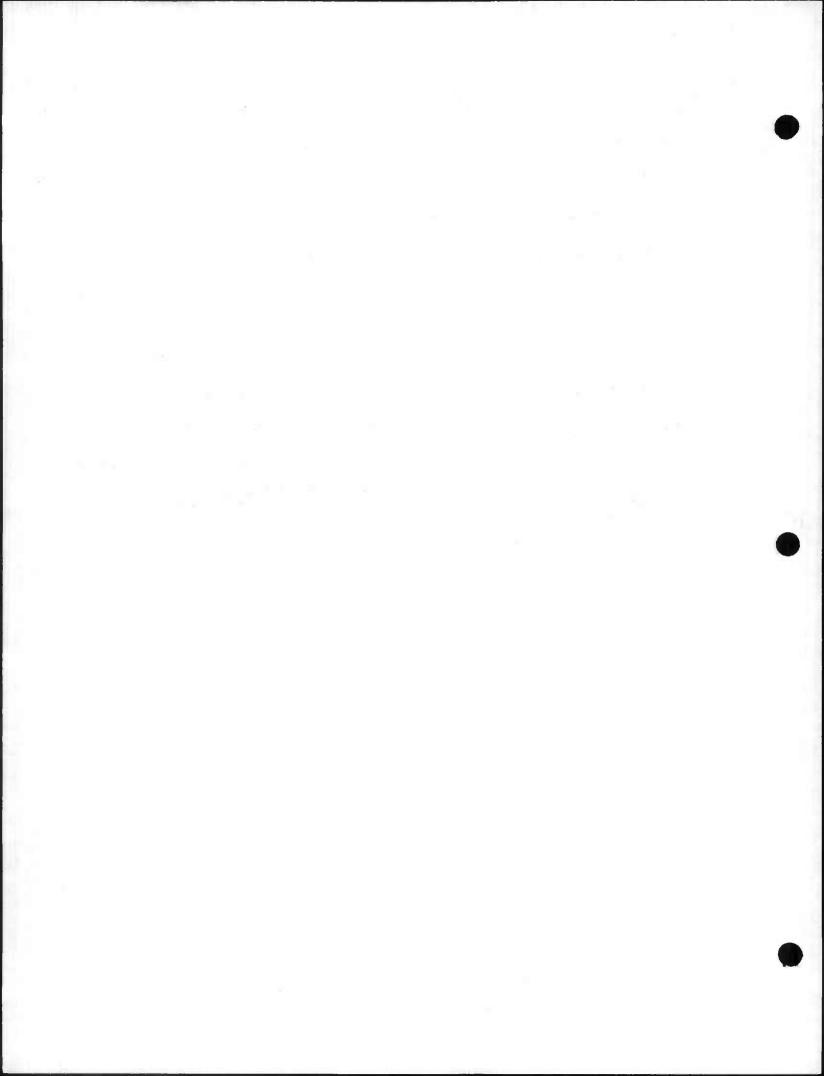
Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

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198. Animomaria Name/Realizaria (Type, Print) 198. Mailing Address (Streat and Number or Rural Reade Number, Chy or Town, State, 2p Code) 19702 20s. Method of Disposition 198 Burist 2 Commation 3 Disposition (Name of Disposition 198 Burist 2 Commation 3 Disposition (Name of Disposition 198 Burist 2 Commation 3 Disposition (Name of Disposition 198 Burist 2 Commation 3 Disposition (Name of Disposition 198 Burist 2 Commation 3 Disposition (Name of Disposition 198 Burist 2 Commation 3 Disposition (Name of Disposition 198 Burist 2 Commation 199 Burist 199 Buri	0	Rene' A. Jur	ıca				Max	т.	11 Doct	_		
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State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene

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Physic /Medi		THOMAS DOLL J	ACKSON				Month FEBRUA	RY 27,	997	3:48 A.M.
Exami		4a. Facility Nama (If not institution, give	street and number)			4b. City, Town, or I	ocation of Dear			
		MALCOLM GROW MEDI				CAMP SPRI		PRINCI	-	
Funeral Director			ax 7. Aga (In yr		f Under 1 Yaar fonths Days			th ay, Year 1032 14,199		laca (State or Foreign try) nington D.(
E S E		Usual Rasidance of Decedant 10a. Stata 10b. County	10c. 6	City, Town or Locati	lon				1	0d. Inside City Limits
Maryar e-f show filed.et	tor	Maryland Prince G	eorge's Dis	strict He	ights					1 XYas 2□ No
death with the Marytand ms 23a or 28a-f show cinust be notified at	Funeral Director	10e. Street and Number 1903 Wintergreen	Court		10f. Zip Coda 20747			10g. Citizen of United S		•
or the	by	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Evar In Armed Forcas? 1 1 Yas 2 70 1f Yes, Giva Yaar or Datas:	U,S. 13. Was if Ya rears	S Decedant of I as, specify Cub Yas 2 No	Hispanic Origin? (S lan, Maxican, Puart Specify:	pecify Yas or No Rican, atc.)	5- 14. Rai Bia Specif	ce - Amaric ck, Whita,	atc.
15-002 72 hours "netural", adical Ex	eted	15. Decedant's Ed (Specify only highest gra		16a. Decedant	's Usual Occu d of work done	patton during most of wor	king	16b, Kind of B	usinass/inc	dustry
within than	Completed	Elemantary/Seaondary (0-12)	Coitega (1-4or 5+)	Staff S	NOT use retire	ed)		U.S. A	r For	rce
		17. Fathar's Nama (First, Middle, Last)				18. Mothar's Nan	na (First, Middle			
irylan should be of Mental marked o	To Be	Thomas Jackson				Tiny	Bundy			
Maryland d2 should be lile th and Mental Hy 7 is marked oths traumatic event	-	19a, Informant's Name/Ralattonship (7	**************************************	19b. Mailing A	Addrass (Stree	t and Number or Ru	ral Routa Numb	er, City or Town	, Stata, Zip	Code)
C TO NO. AL		Loretta Y. Jack				green Cou				, Md.20747
Page Nent of Int or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Ramoval from Stata)	Place of Disposition comparts, cremate N	on or other pla	Cemeter	y 3/4	Laurel,		
Balti permit. Departri Imports siny inju		21. Signature of Funaral Sarvice Licen	pe Dr.	322. No	ama and Addre E Funer 8 Marie	ass of Facility al Homes oro Pike	Forest	ville, N	laryla	and 20706
68760, tiflcate be executed EX EX EX EX EX EX EX EX EX EX EX EX EX	edical Examiner	Immediata Causa (Final disass or condition rasulting in death) Sequentially list conditions, if any, laading to immediate causa. Enter Underlying Ceuse (Disassa or injury that initiated evants rasulting in death) Last	b. MYOCARDIAL Dua to C. CORONARY AR Dua to	(or as a consequent TERY DIST (or as a consequent	nce of): ON oce of): EASE oce of):	ILURE				
			d. CHRONIC HYP	ERTENSION	1					
that the deeth atte detached for	Physician/N	Part II. Other eignificant conditions co	ontributing to death but not re	esulting In the under	riying causa gi	van in Part I.		tobacco use co		the cause of death?
aw requires s been sign 2 should be	Completed by P						24a. Was	an autopsy ormed?	24b. We	ere eutopsy findings ailable prior to mpletion of cause death?
= F # &		OF Was and referred to medical						Yas 20 No	10]Yas 2□ No
	o Be	25. Wes casa rafarred to medical examinar? 1 ☑ Yas 2 ☐ No	Hospital: 1 ☐ Inpatiant 2	☑ ER/Outpatient	3□ DOA Oti	26. Place of Dea		one) dance 6 ⊟Oti	ns (Canail	al.
O Ph Ne thi	-	27. Mapnar of Death 1 Accidant 5 Panding invastigation	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Inju Wo			how injury occur		<i>n</i>
Division of Attending after death. Director: After d in by the fune	Certification:	3 ☐ Suicida 6 ☐ Could not be 4 ☐ Homicida datarmined	28a. Place of Injury - At building, etc. (Spec	homa, farm, street, cify)	factory, office	li e	28f. Location (City or To	Street and Numi wn, State)	ber or Rura	l Route Number,
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: At completely filled in by the fu	edicai C	29a. Certifiar 1 Certifying Phy (Check only one) 2 Medical Exam	reician: To the best of my kr iner: On the basis of examir and mannar stated.	nowledge, deeth oc nation and/or invast	curred at tha ti igation, in my o	ma, date and place opinion, daath occur	, and dua to tha rred at tha tima,	causa(s) and m data and place,	annar as si and dua to	ated. the cause(s)
To th Vithir Comp	Me	29b. Signatura and titla of certifiar	2/slow	es /	29c. Licano VAO10	sa number 01053519		29d. Data signe FEBRUAR		
(10)	10	30. Name and addrass of person who of BRAD GOLDMAN, CPT		em 23a) (Type, Prin	1050	W PERIME		2-6600		
Sta Regist	- 6	31. Data filed (Month, Dey, Year)	32. Registrer's Sign			THE PARTY OF THE	- W / V			

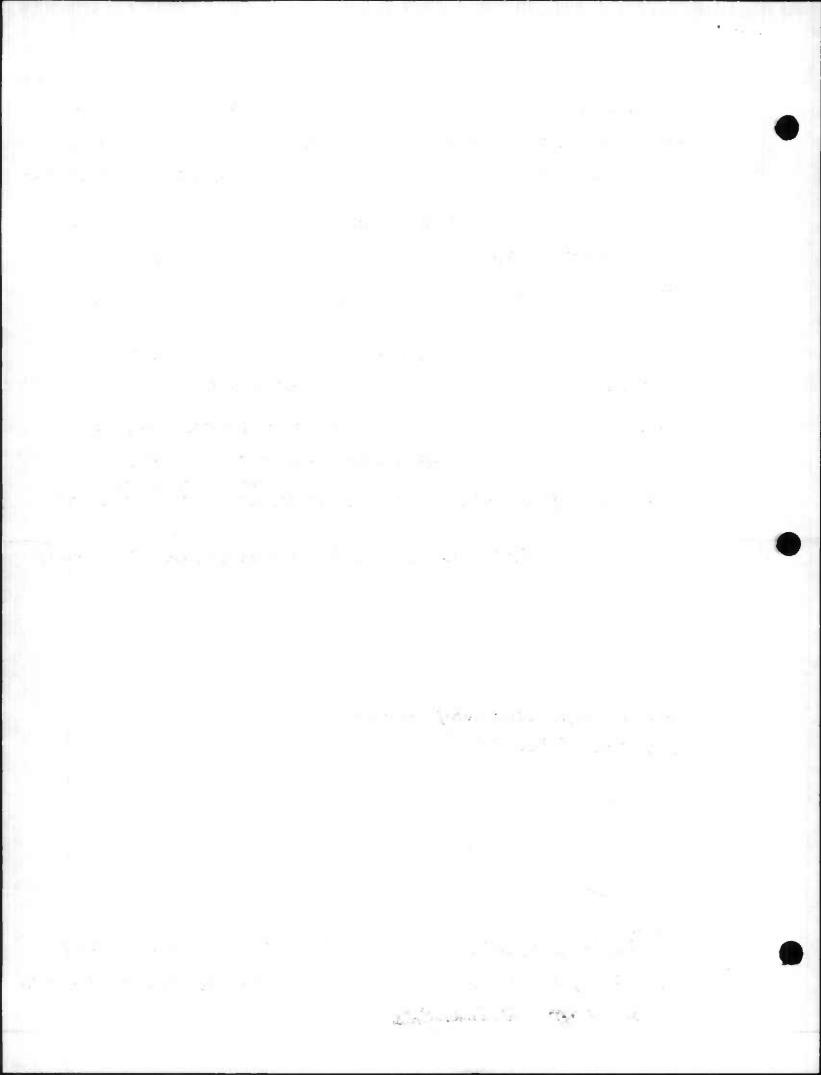
State of Maryland / Department of Health and Mental Hygiene

					idiyidiid / L	Certificate			, ,	eg. No.	97	00000
ı	Physic		Decedent's Name (First, Middle, L TERRENCE	GAST(ON	JOHNS	ON		2. Date of Dea Month FEB	Day 27, 199	Year 9.7	3. Time of Death 10:34 AM
	/Medi Examii		4a. Facility Name (If not institution, g)			ity, Town, or L	ocation of Death	4c. County		10.54411
	Funeral Director		5. Social Security Number 6. 578-94-9435		ge (In yrs. last bir 34	thday) If Under 1 Months	Year If	Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day 02 27		9. Birthpi Coun	lace (State or Foreign try) ington, D.(
	r 28a-f show	2	Usual Residence of Decedent 10a. State 10b. County N/A N	/A	10c. City, Tow		C				10	0d. Inside City Limits
	vilh the A r or 28a-1 be notifi	Direct	10e. Street and Number 3059 Porter Str		Wasii	ington, D	ode		1	0g. Citizen of		
020	ours after douth with raff, or thems 23a or Examiner mast be	by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 🖾 Divorced	12. Was Decedent Armed Forces 1 Yes 2 X If Yes, Give Year or Dates:	No			nic Origin? (S) lexican, Puerto pecify:	pecify Yes or No- o Rican, etc.)		ce - America ck, White, o	etc.
Maryland 21215-0020	hin 72 h	Completed	15. Decedent's E (Specify only highest gi	ducation	16a.	Decedent's Usual (Give kind of work life. DO NOT use	Occupetlor done durin retired)	n g most of wor	king	16b. Kind of B	usiness/Ind	lustry
ind 21	be filed will tal Hyglens d other the event, the	Be	17. Father's Name (First, Middle, Las	0		Student			ne (First, Middle, I	Priva Meiden Suman		
laryla	2 should be and Menta is marked numetic ex	To	Robert Melvin 19a. Informant's Name/Relationship		1	. Mailing Address (Helen <i>Number or R</i> u	Bethea ral Route Number	, City or Town	State, Zip	Code)
Baltimore, N	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.		Robert Melvin Jo 20a. Method of Disposition 1⊠ Burial 2 □ Cremation 3 (4 □ Donation 5 □ Other (Speci	Removal from State	20b. Placa of cemeter	749 Greym Disposition (Name ry, cremetory or oth ny Memori	of er place)	. !	03/04	20c. Location	City or To	and 20785 wm, state aryland
Balti	permit. Pa Departmen Important: any injury once.		21. Signeture of Funeral Service Lice Noney A. 23a. Part1. Enter the disease, or corshock, or heart feilure. List only	1.	د	22. Name and J. B.	TENIZ T	Fecility	EDAL HOM	1		
68760,	Physician produced by the prival-transit as the burial-transit as the prival-transit as	edicai Examiner	shock, or heart feilure. List only immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		nshot	wound consequence of):					1	thiervel Between Onset and Death
P.O. Box	ss that the death cer gned by the attendir be detached for use	by Physiclan/M	Part II. Other eigniftcent conditione	d	out not resulting in	the underlying cau	ise given in	Part I.		obacco use co		the cause of death?
Records,	aw 2 si b	Completed							24a. Was a perform	n autopsy ned?	ava	ore eutopsy findings allable prior to appletion of cause death?
	Physician: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:					th (Check only on	_		ďYes 2□ No
Division of Vital	Attending Physic death. Sector: After this by the funeral di	Certification: To	27. Manner of Death 1 Natural 2 Accident 3 Sulcide 4 Homicide	28a. Dete of Injunction (Month, Detection 2-2.7- 28e. Plece of In	17y 28b. 1 27 00	Time of highly 286 August 286 Aug	i. Injury at Work? 1 ☐ Yes	2 ⊠ No	ome 5 Reside 28d. Describe ho Selfinfl 28f. Location (St City or Town Aberder	icted q reet and Number, State) 916	unshe ber or Rurai Barne	t wound PRoute Number,
	To the Hospital or A within 24 hours after To the Funeral Direction plately filled in by	edical	29a. Cartifier (Check only one) 1 Certifying Pl	nyelclan: To the best miner: On the basis o and manner st	of my knowledge of examination and	, death occurred et	the time, d	ate and place,	end due to the ca	ause(s) and me	anner as st	ated.
	To the within 2	×	29b. Signeture and title of certifier 30. Name and address of person who STEPHEN S. RAD			MP 0	.C.M	. E		FEB. Marvl	28,	1997
	Sta Registr		31. Date filed (Month, Day, Yeer) MAR 06 19.	32 Regist	rer's Signature							

who were the sale with the sale.

			State of Maryland / Department of Health Certificate of Death			ene g. No.	97	08296
	Physici /Medi		Decedent's Name (First, Middle, Last) WILLIE JONES		2. Date of Deeth Month MARCH 1	,Day 1997	Yeer	3. Time of Death 8:30am
	Examir Funeral Director		HYATTSVILLE HEALTH CARE CENTER HYAT	TSVIL	LE 8. Date of Birth (Month, Day, 1) AUG 6,	(ear)	9. Birthpli Count South	EORGES ace (State or Foreign n) Carolina Od. Inside City Limits
	ith the Maryland or 28a-f show be notified at	Director	WASHINGTON, D.C. 10e. Street and Number 10f. Zip Code		109	g. Citizen of W		1 ☐ Yes 2 ☐ No
020	72 hours after desth with Instured, or Harms 23e or disel Examiner must be n	by Funeral	2855 BLADENSBURG RD, N.E. 11. Marital Status 12. Wes Decedent Ever in U.S. Armed Forces? 1	an, Puerto F	city Yes or No-		e - Americe k, White, e	etc.
Maryland 21215-0020	filed within 72 ho Hygiene. Sher than "naturn ent, the Medical.]	Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 8th 16a. Decedent's Usual Occupation (Give kind of work done during mo life. DO NOT use retired) PAINTER		ng	Sb. Kind of Bu	siness/ind	
ryland	d Mental H marked oth mattic even	To Be	17. Father's Name (First, Middle, Last) 18. Moth	BARA	(First, Middle, Ma BURROUGH	IS		Control
Baltimore, Ma	Pages 1 and 2 a nert of Health an int: if them 27 is a rry or other trau		BARBARA PHTILIPS 20a. Method of Disposition 1 \$\infty\$ Burial 2 \$\infty\$ Cremation 3 \$\infty\$ Removel from State 4 \$\infty\$ Donation 5 \$\infty\$ Other (Specify) 1 \$\infty\$ Burial 2 \$\infty\$ Cremation 3 \$\infty\$ Removel from State	E RD	#203 LAU		207 City or Tox	708
Balti	Departs Departs Imports any Inju		21. Signature of Funeral Service Licensee 22. Name end Address of Faci	JOH	NSON & J E. WASHI	ENKINS	INC.	
	Physician /Medicai Examiner	er	23e. Pent 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such a shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):			,		Approximate friterval Between Onset and Death
Box 68760,	death certificate be executed e attending physician and of for use as the burial-trensit	n/Medicai Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of):					
P.0.	thet the ded by the	y Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part Office Obsticutive Libra Dislase	t I.		acco use con	/	the cause of death?
Records,	aw requires seen seen seen seen seen seen seen s	Completed by	DIAGETES MELLITIS		24e. Wes an performe	autopsy ed?	eve	re autopsy findings flable prior to appletion of cause leath?
Vital R	Physician: The la this certificate ha ral director, page	Be	examiner?	ce of Death	1 ☐ Yes		1 🗆	Yes 2□ No
of	or Attending Physite death. Nector: After this in by the funeral di	Certification: To	1 Yes 2 No	⊇No 2	ne 5 Residen 8d. Describe how 8f. Location (Stre City or Town,	Injury occurr	ed	
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medicai C	29a. Certifier (Check only one) 1☐ Cartifying Physician: To the best of my knowledge, death occurred at the time, date a 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated. 29b. Signature end title of certifier 29c. License number	eath occurre	d at the time, date	se(s) and ma e and place, a d. Date signed	and due to	the cause(s)
			30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Pari A. DEVORE MD 4203 OVERVSSUN	12	1	ARCH	2 /	997
	Sta Registr		RANI A. DEVORE MD 4203 (DUEENSSUM 31. Date filed (Month, Day, Year) MAR 06 1997 AUX Studies Reveal	y Ro	1 Hya	ithrii	lle A	10 2028,

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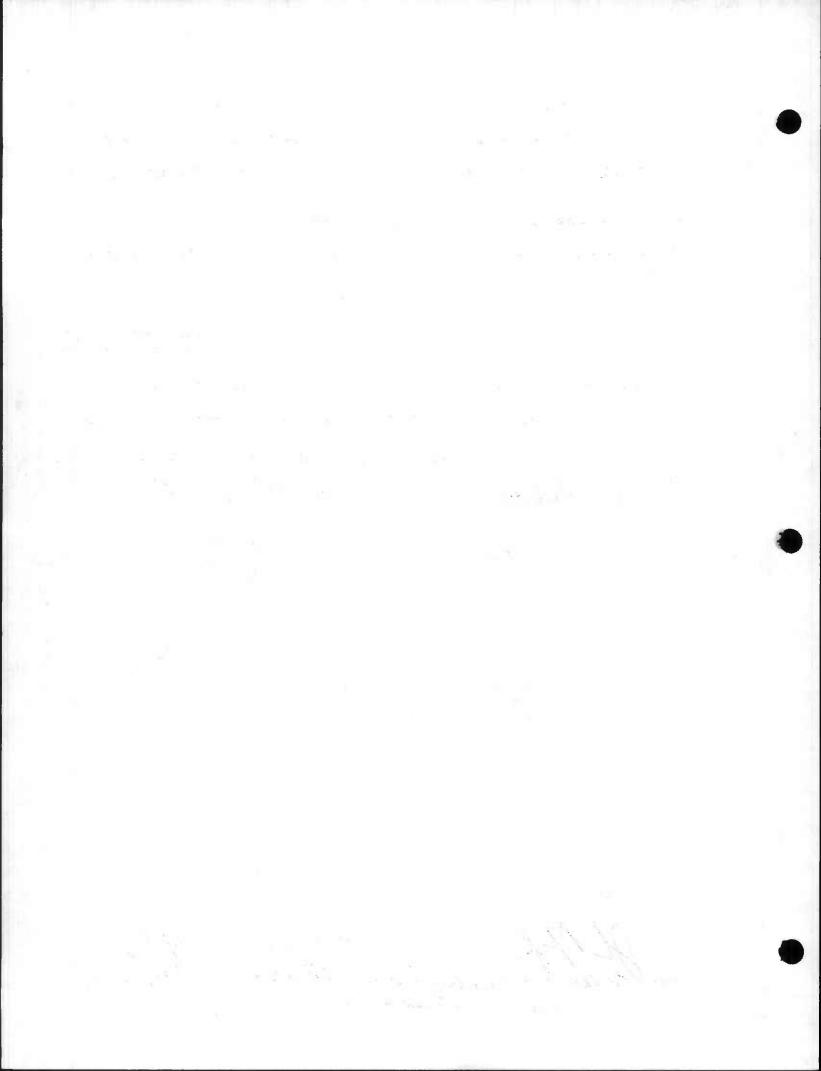


State of Maryland / Department of Health and Mental Hygiene

08297 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Celia Kaplan March 4, 1997 9:25 AM /Medical 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Manor Care-Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) **Funeral** 1□M 2X F Months Devs Hours 81 Director 358-03-2169 Sept. 13,1915 Illinois Usual Residence of Dacaden 10a Stete 10b. County 10c. City. Town or Location 28a-f show 10d. Insida City Limits the Maryla the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? items 23a or 20910 1925 Grace Church Road United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, spacify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Never Married 2 Merried 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 8 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Agricultural Dept. d Hygiene. Elemantary/Secondary (0-12) Collaga (1-4or 5+) 12 Federal Government Director 17. Father's Name (First, Middle, Lest) 18. Mother's Nama (First, Middle, Meiden Sumeme) Pages 1 and 2 should be fill ment of Health and Mental H tant. If Item 27 is marked oth Be traumatic 2 Bernard Kaplan Lillian Muchnik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) statement of Health Important if Item 27 is any Injury or other 1900s. Jean K. Teichroew/Niece 1925 Grace Church Road, Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, cremetory or other place March 5,1997 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland 21. Signatura of Funeral Service Licensea 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc., 75
Bethesda, Maryland 20814-3501

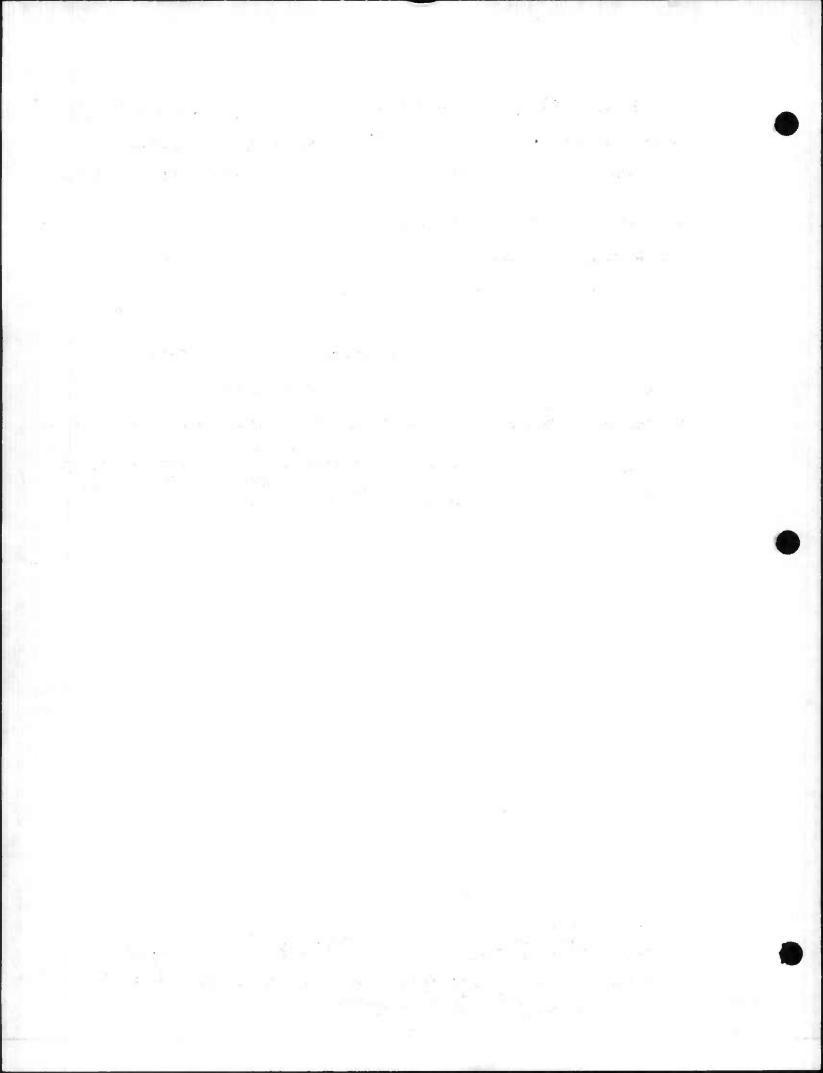
23a. Part1. Enter the disaase, or complications that causad the death. Do not enter the mode of dying, such as cardiac or respiratory errest, 7557 Wisconsin Ave. Approximate Interval Batween Onset end Deeth **Physician** /Medical Immediate Causa (Final neumonia disease or condition rasulting in death) **Examiner** Due to (or as a consequence of): Examiner The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Undarfying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physician a Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as e consequence of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detach perkension; Pernicious Gnemia 1 Yes 2 No 3 Probably 4 Sunknown by 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed ate hes t 1 ☐ Yes 20 No 1 ☐ Yes 2 No certificate or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1'□ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: Affer 5 Pending Investigation 1 Natural 2 Accident 1 Yes 2 No 24 hours after death. Funeral Director; A the 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28a. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) end manner stated. Medical 29a. Cartifier (Check only one) within 2 To the 29b. Signature and site of bertifie 29c. License number 29d. Date signed (Month, Day, Year) ss of persog pleted causa of death (Itam 23a) (Type, Print) Powie Red # 307 MARGOLIS 14333 Zgurel 32. Registral s Rignardre 31. Date filad (Month, Dey, Year) State MAR 0 6 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physicia	an	1. Decedant's Nama (First, Middla,	Last)	1	KEN HE	- 0			2. Data of [Month		Day	Yaar	3. Tima of De
/Medic		EVELYN	MARY		CON HE	307			Feb	26	19	97	7:4000
Examin	er	4a. Facility Neme (If not institution,	Part Call Part and	ber)			4b. Cit	y, Town, or	Location of Dea	ath	4c. Count	y of Death	
		Holy Cross Hos					Si	lver	Spring		Mont	gomer	у
Funeral		5. Social Sacurity Number	6. Sax 7 1 □ M 2 XF	7. Age (In yrs	. last birthday)	Months	1 Year If U	ndar 24 Hrs	8. Deta of 8	Birth Day, Yes	ar)	9. Birth	oleca (Stata or Fo
Director		578-30-0016		69	Yrs.				May 30), 1	927		ington,
		Usuai Rasidanca of Dacedant 10a. Stete 10b. County		10c C	ity, Town or Lo	ocation							10d In-14- 0h I
ms 23a or 28a-f show cmust be notified at	-												10d. Insida City L
88.8	Director	Maryland Montgor	nery	Ro	ckville								1 ☐ Yes 2
5 8	듬	10e. Streat and Number				10f. Zip	Coda			10g. (Citizan of	What Cou	ntry?
55 H	<u>a</u>	4807 Boiling Bro	ook Parkwa	ay		208	852			Uni	ted S	State	S
	Funeral	11. Marital Status	12. Was Daced Armed Ford	cas?	J,S. 13.	Was Daced	lant of Hispani	c Origin? (S	Specify Yes or Note Rican, atc.)		14. Rad		can indien,
tural, or the	F	1 Navar Married 2 Marrie	d 1 ☐ Yas 2 If Yes, Giva	2 XNo		1 ☐ Yas 2			10 7110-111 (210.)				ato.
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E . E .	2	James Curtin					Ma	rgare	t Rucke	er			
h and Mer 7 is marke traumatic		19e. Informant's Name/Ralationship	p (Type, Print)		19b. Mailir	ng Address			ural Routa Num		or Town	State, Zip	Coda)
4 tr		William Kennedy,	/Husband		4807	Boili	ing Bro	ok Pa	rkway,	Roc	kvil]	le, M	D 20852
of Health Isem 27 r other to		20a. Mathod of Disposition			Placa of Dispo	osition (Nam	na of		Data	-		City or To	
		1 Deurial 2 Crametion 3 4 Conation 5 Other (Spe	I □Removal from Si cifv)	tata	te of		March	3, 19	197	03	1	Cond	- MD
Department Important: any injury once.		21. Signature of Funeral Servica Lic	N	Ga	22	2. Name end	d Addrass of F	ecitity Ro	hert A	P111	mphre	SPIT.	ng, MD neral H
O T F O		1 1 .06			Re	ockvi]	lle, In	c. 30	0 West	Mon	tgome	ery A	venue
	-	/ Course	Terry.		803 R	ockvil	lle. Ma	rvlar	d 2085	50-2	805		
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286. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) NA 287. Certifier (Check only one) 298. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) NA 299. Certifier (Check only one) 290. Date signed (Month, Day, Year) 290. Date signed (Month, Day, Year) 290. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) G.S. Prabhu M.D. 1810 Belair Rd #102 Fallston MD21047 410-879-6564			**	1 L Inpate		patient 3L DOA	4 Nuising Fi				fy)
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Registrar MAR 0 5 1997 Schi Studen Redall							ralisto	on MD2	104/ 4]	0-8	19-6564
Mario			MAR 0 5	1997	hi diwales	x-Rardall					

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month ULYSSES DONALD MARCH 4e. Fecility Neme (If not institution, give street and number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Union Hospital of Cecil County Elkton If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex Birthplace (State or Foreign Country) 1⊠M 2□ F Months Days Yrs. 525-62-1877 64 January 1, 1933 Kansas Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 13 Clearview Avenue 21901 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give 1953 – 1954 Yeer or Dates1957 – 1959 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritel Status 1 □ Never Married 2 □ Married 1 Yes 2X No Specify: Specify: White 3 ☐ Widowed 4 ☒ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 10 Truck Driver Long-haul Trucking 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Kinney Mabel Laughlin 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen M. Schade / Companion 13 Clearview Avenue, North East, MD 21901 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Dete 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removal from State Mar. 10 1997 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris Crematory West Chester, Penna. 21. Signeture of Funeral Service Ucerutia 22. Name end Address of Fecility Crouch Funeral Home 127 South Main Street, North East, MD 21901 23a. P. rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death ARRHYTHMIA (PRESUMED) Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evelleble prior to completion of cause of deeth? 24e. Wes an autopsy performed? 1□ Yes 2E No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one)

Physician /Medical Examiner

physician and the buriel-transit

or attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and

s certificate hes b

Be

Certification: To

Medicai

P.O. Box 68760.

Division of Vital Records,

permit. Pages 1 and 2 should be filled w Department of Health and Mantal Hygien Important if Item 27 is marked other tha any Injury or other traumatic

Physician

/Medical

Examiner

10a State

Funeral

Director

must be notified at

Items 23a

"natural", or items ledical Examiner n filed within 72 hours after Hygiene. ther than "natural", or ite

Director

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Completed

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the Maryland

Baltimore, Maryland 21215-0020

Examiner Physician/Medical þ Completed

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a Funeral Dire

To the Hosp within 24 hor To the Fune completely fi

31. Dete filed (Month, Day, Year) State Registrar

1 Yes 2 No

5 Pending investigation

6 Could not be determined

27. Manner of Deeth

1 Naturel

2 Accident

3 Suicide

29e. Certifier

29b. Signati

4 ☐ Homlcide

(Check only

32. Registrer's Signeture Rid Davidson Pandelle

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se of deeth (Item 23e) (Type, Print)

2 PER/Outpetient 3□ DOA

28b. Time of

Hospital: 1 ☐ Inpatient

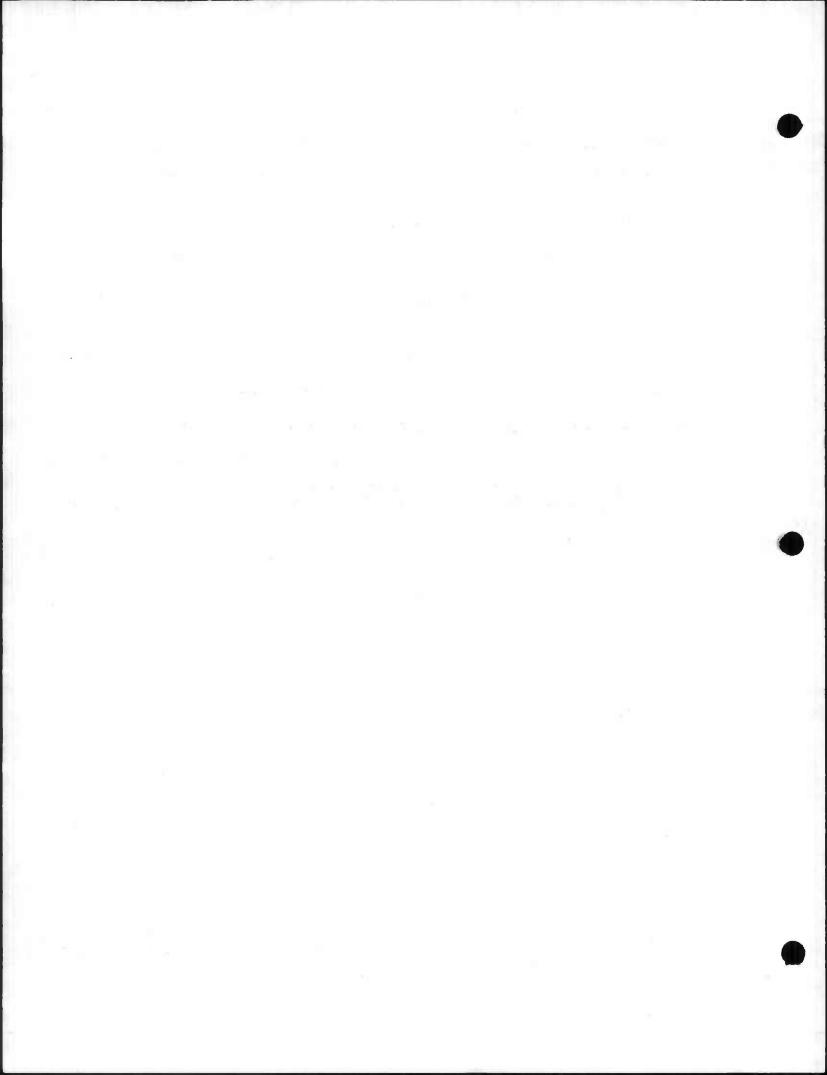
28a. Dete of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28c. Injury et Work? 28d. Describe how Injury occurred 1 Tyes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner stated.



State of Maryland / Department of Health and Mental Hygiene

FORT WASHINGTON, MD 20744

08301

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Dey 1 9 9 7 eer **Physician** FREDERICKA E. KEYS MARCH 6 11:35PM /Medical 4a. Fecility Nema (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner FORT WASHINGTON HOSPITAL FORT WASHINGTON PRINCE GEORGE'S 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Aga (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Year) Birthpiece (State or Foreign Country) **Funeral** 1□M 2X F Months Deys Hours Yrs. 578-07-0497 Director 97 MAY 6, 1899 MARYL AND Usuel Residence of Deceden 10e. Stete 10b. County 10c, City, Town or Location 10d. Inside City Limits the Marylar than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 No Director MARYLAND PRINCE GEORGE **ACCOKEEK** 10e, Street end Number 10f. Zlp Code 10g. Citizen of What Country? #17319 LIVINGSTON ROAD Funerai 20607 UNITED STATES 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Reca - Amarican Indian, Biack, Whita, atc. 11. Meritel Status 72 hours after 1 Never Merried 2 Married Maryland 21215-0020 1 Yes 200 Specify: Specify: BLACK Š 3 Widowed 4 □ Divorcad "natural", Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuei Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT use retired) Hygians. Elemantary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygian
Important: If them 27 is marked other tha
any injury or other treametic. 12TH GRADE HOSTESS WEST CHESTER CORP. 17. Father's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be JAMES H. BROOKS NANCY MAHONEY BROOKS 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Steta, Zip Code) PHELICIA BOYER / NIECE 2570 MARSHALL HALL ROAD, BRYANS ROAD, MD. 20616 Baltimoré, 20a. Method of Disposition 20b. Pieca of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 1 ⊠ Burial 2 □ Cremetion 3 □ Ramoval from Stete 4 ☐ Donetion 5 ☐ Other (Specify) METROPOLITAN CHURCH CEM. 3/11/97 POMONKEY, MARYLAND 21. Signature of Funeral Service Licenses

DIA C. THORNTON JOHNSON MO0583 22. Nama and Addrass of Facilit THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640 23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel COLLAPSE YOCARDIAL 3 days diseasa or condition rasulting in deeth) Examiner Dua to (or es a consequence of): Examiner CONGESTIVE

Due to (or es a consequenca of): HEART FAILURE the bunai-transit be axecuted Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Disaase or Injury that initioted evants rasulting in death) Last and Box 68760, physician C. ATHEROSCLEROTIE CARDIOVASCULAR DISEASE Physician/Medical Dua to (or as a consequence of) 888 attending usa ò Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? ed by th 1 ☐ Yes 2 No 3 ☐ Probebly 4 ☐ Unknown signed b Records, à 24b. Were eutopsy findings eveileble prior to completion of cause of death? should 24a. Was en eutopsy performed? Completed page 2 has Tha cartificata 1 ☐ Yes 258 No 1 ☐ Yas 2 No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this cartifice 25. Wes case referred to medical Be 28. Pleca of Deeth (Check only ona) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) P 1 Yas 2 No 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Tima of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident MIA NIA by tha 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be determined 28e. Plece of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours after To the Funeral Dir MA 15 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end piece, and due to the cause(s) end menner stated. Medicai 29a, Certifier (Check only one) 29b. Signeture and title of cartifian 29c. License number 29d. Data signed (Month, Day, Year) 30. Name end address of person who completed cause of deeth (Itam 23e) (Type, Print)
HERRY E VICTOR, MD 11701 LIVINGSTON RD 3 120986

State Registrar

32. Registrar's Signature 31. Dete filed (Month, Dey, Year) MAR 1

State of Maryland / Department of Health and Mental Hygiene

						Certificate of	Death	R	eg. No.	97	0.830
в	Physic	ian	Decedent's Neme (First, Middle, La	ast)				2. Dete of Deel Month	Day	Yeer	3. Time of Deet
	/Medi		DONALD	KENNEY				FEBRU	ARY 25,	1997	11:26AM
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			Prince Georg 5. Social Security Number 6.	e's Hospit	al	N Hadas 4 Van	Chever	y			orge's
	Funeral Director		293-26-7631	Sex 7. Age (In	C 0	day) If Under 1 Year Months Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey, 03 - 22	Year) - 3 4	9. Birthpl Count	ace (State or Fore try) hio
	¥		Usuel Residence of Decedent 10e. Stete 10b. County	10	c. City, Town	or Location				11	Od. Inside City Lim
	o Maryi Sa-f sho diffed a	Director	Maryland Prince	George's			ndover				1X Yes 2
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020	n 72 hours after death with the Marylar hetures, or liems 23e or 23e-f show ideal Examiner must be notified at	by Funeral	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 XYes 2 No 2 if Yes, Give Yeer or Dates: 2		1 Vos W No		cify Yes or No- Rican, etc.)	Blac	e - America ck, White, e : Bla	etc.
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, Maryland 21215-0020	and 2 sho saith and 127 is ma or traums		19e. Informent's Name/Reletionship Ida Kenney/Wife	(Type, Print)	1 ^{9b.}	Mailing Address (Street O Columbia	Avenue, L	Route Number andover	, City or Town, Mary	Stete, Zip Tand	20785
	artment of He ortant. If item injury or oth		20e. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci	Removal from Stete	Ob. Plece of I cometery Mary 1 a	Disposition (Name of crematory or other plain nd Veteran	s Cem. 3/	3/97 C	20c. Location - Chelten		wn, Stete Maryland
Dair	Departr Departr Imports any inju		21. Signeture of Funeral Service Los	nsee			ess of Fecility kins Funer dover Road			arvla	nd 20785
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8 1	Physician										Onset end Death
1	/Medical Examiner		Immediate Cause (Final disease or condition	MASSIVE	RILAT	ERAL PULMON	INDV EMBOL	т			48 hra.
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	ysician: The s certificate director, pag	Be	25. Wes case referred to medical				26. Plece of Deeth	(Check only on	e)		
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5	if or Attendi	Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - building, etc. (S)	At home, farr pecify)	n, street, factory, office	2	Bf. Location (St. City or Town		er or Rural	Route Number,
	the Hospital or Attending Phin 24 hours efter deeth. The Funeral Director: After thin mpletely filled in by the funeral	edicai C	29a. Certifier (Check only one) Certifying Pt Medical Example (Check only one)	nyeician: To the best of my niner: On the basis of exe and menner stated.	knowledge, minetion end/	deeth occurred et the ti or Investigetion, in my o	me, dete end plece, e opinion, death occurre	nd due to the ca d et the time, de	ause(s) end me ete end plece,	enner as ste end due to	eted. the ceuse(s)
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	Sta Registr		31. Dete filed (Month, Day, Yeer) MAR 03 199	Registrar's 6	Signatur	Less .			1 1 4	othered	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedent's Nama (First, Middla, Last) 2. Data of Death Month **Physician** Hawa Vandi Koker /Medical February 25, 1997 5:45 PM 4a. Facility Nama (If not institution, give straat and number) 4b. City, Town, or Location of Daath Takoma Park

If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year)

June 30, 1924 4c. County of Daath **Examiner** Washington Adventist Hospital Montgomery 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1□ M 2 F 72 Director 579-78-1215 West Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City. Town or Location or 28a-f show 10d. Insida City Limits Examiner must be notified at Director 1 ☐ Yas 2 ☑ No Maryland Prince George's Landover Hills 10e, Straet and Number 10f. Zip Coda 10g. Citizan of What Country? 238 3902 70th Avenue Funerai United States Berne 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Give 11 Marital Status Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) Raca - American Indian, Black, White, atc. 72 hours after 1 Navar Marriad 2 Marriad ò 1 ☐ Yas 2 ☒ No Specify: þ Specify: 3₺ Widowad 4 Divorced Black. Year or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retirad) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be flied within 1 Department of Health and Mental hygiene. Important: If them 27 is marked other than "n any injury or other traumatic event, the Med Elamantery/Secondary (0-12) Collega (1-4or 5+) Homemaker 12 Own Home 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be 2 Vandi Koker Satta Bockarie Navo 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rurel Route Number, City or Town, Steta, Zip Coda) Juanah Lamin Koker, Son 8218 La Almendre Way, Sacramento, California 95823 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1₺ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Fort Lincoln Cemetery 3-8-97 Brentwood, Maryland 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility
Fort Lincoln Funeral Home, Inc.
3401 Bladensburg Rd., Brentwood, Maryland 20722 23e. Part1. Entar the disaasa, or complications that causad tha daath. Do not antar the moda of dylng, such as cardiac or raspiratory arrast, shock, or hear feilura. List only one causa on each lina. Approximate Intarval Between Onset and Death **Physician** /Medical Immediata Cause (Finel disaasa or condition rasulting in daath) **Examiner** Examiner The law requires that the death certificate be axecuted for use as the burial-transit Sequentially list conditions, if eny, laading to immadiata causa. Enter Underlying Causa (Diseasa or Injury that Initiated events rasulting in daath) Last Dua to (or as a consequence of he. Physician/Medical Dua to (or as a consequanca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Š 8 Completed 24b. Were eutopsy findings available prior to completion of ceuse of deeth? 24a. Was an autopsy performad? certificate has 2 1 No 1 Yas 2 No Physician: Be 25. Was casa rafarred to madicel axaminar? 26. Placa of Death (Chack only ona) Hospitel: Other: 4 Nursing Home 5 Rasidance 6 Othar (Spacify) Certification: To 1 Yas 2 No 1 Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA this 27. Manner of Daath 28a. Data of Injury (Month, Day Year) 28b. Tima of After t 28c. Injury at Work? 28d. Dascribe how injury occurred Attending s after dea...al Director: After 1 Natural 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 6 ☐ Could not be datamined 3 ☐ Sulcide 28a. Place of Injury - At home, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stete) filled in by 4 Homicide

P.O. Box 68760, Records, Division of Vital ò

Baltimore, Maryland 21215-0020

To the Hospital or within 24 hours at To the Funeral D

Medicai

29b. Signatura and title of certifiar

-20062

29d. Data signad (Month, Day, Yeer)
Feb-, 28th, 1997

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) St. BILVER SPRING, MARYLAND 20910

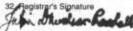
TONY P. ILAWNARICAT. 8201 16 St. BILVER SPRING, MARYLAND 20910

1 🗹 Certifyling Physician: To tha best of my knowledge, death occurred at tha tima, data and plece, and dua to the ceusa(s) and manner as steted. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at tha time, data and place, and due to the ceusa(s) and manner stated.

31. Date filed (Month, Day, Year) State

29a. Cartifiar

MAR 03 199



Registrar

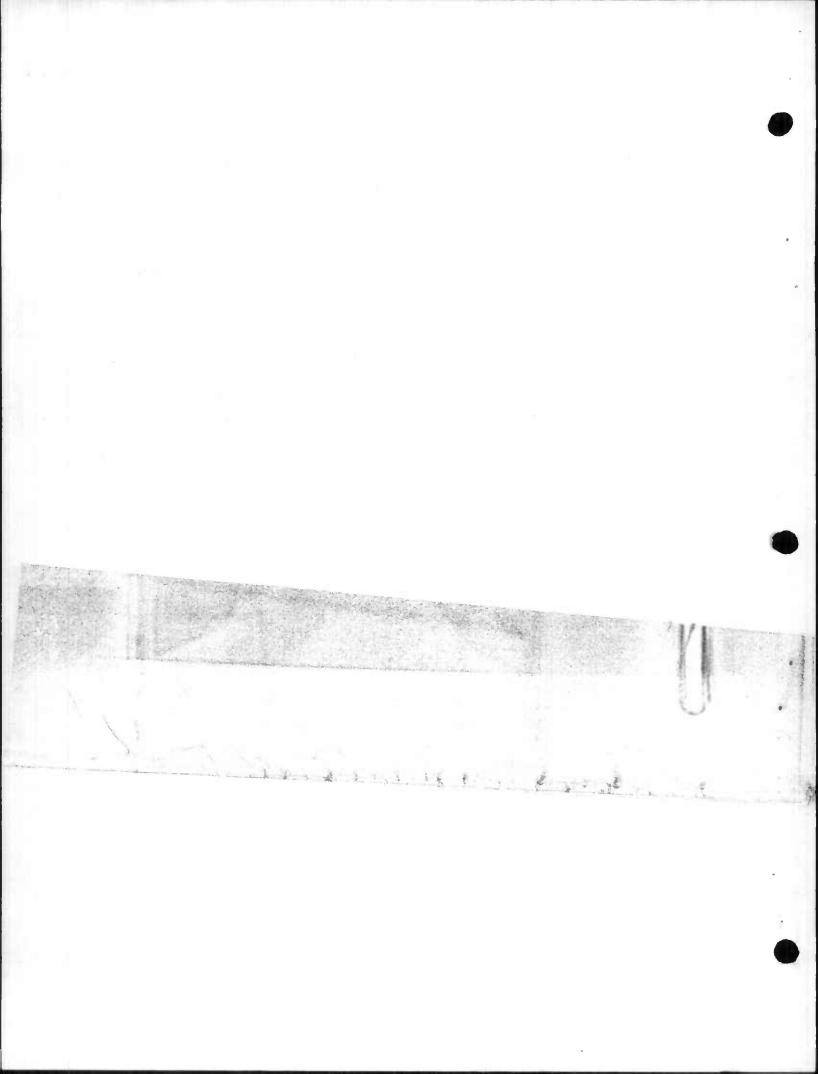
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ew	BALTIMORE, MARYLAND 21203-3146	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within . Neurs after death. Page 6 may be retained by the hospital or attending physicial	TO THE FUNERAL DIRECTOR: After this centificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the build-for the bu	DE MED WIGHT IS THOUS SHE GRALL WITH THE STARK DEPT. OF TREATH AND METHOD FIRST COUNTY, OF THE MEDICAL EXAMINER MUST BE NOTIFIED AT ONCE.
	DIVISION OF VITAL RECORDS; P.O. BOX 13146,	executed with	in and complete	umatic event
	S. BOX	ertificate be	ing physicial	other trau
	S; P.C	the death c	the attend	injury. or
	RECORD	requires that	een signed by	Shows any
	ITAL B	N: The law	icate has be	item 23
	OF V	PHYSICIAL	this certif	srked, or
	ISION	ATTENDING	CTOR: After	28 is ma
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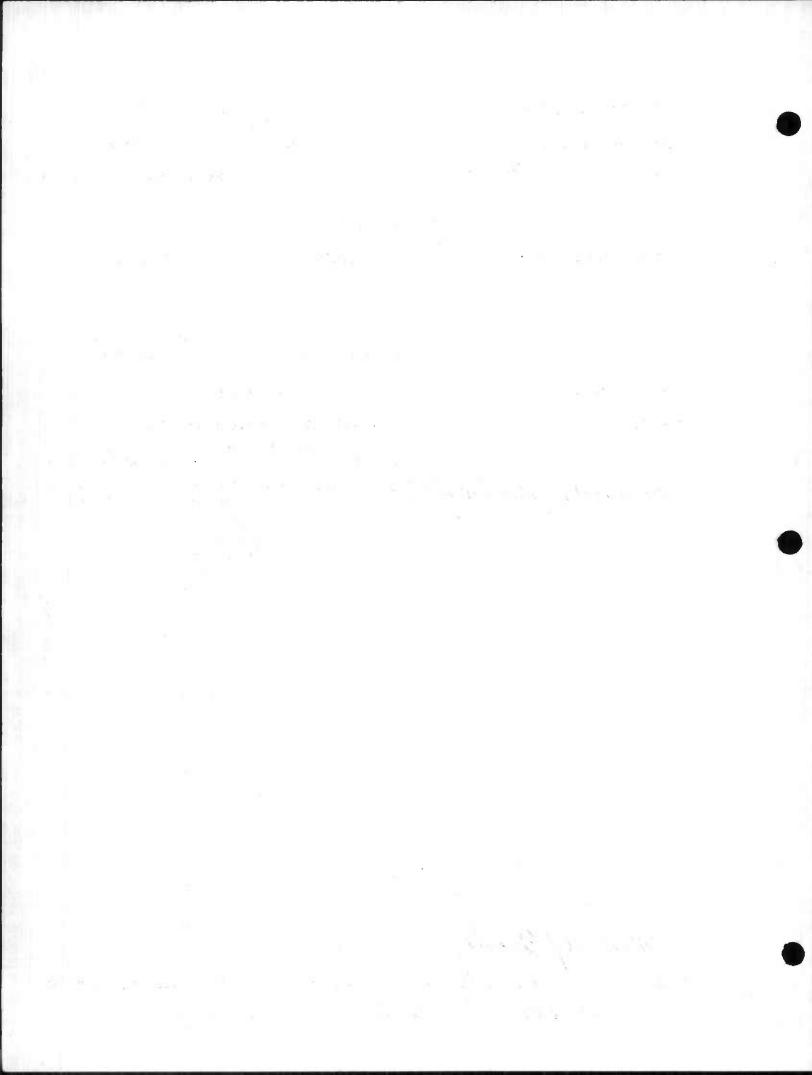
	1. DECEDENT'S NAME (First, Middle Louise Eli	za.	beth Gu			ICATE 1Z				2. DATE OF DEATH MONTH 02	DAY 10	9 ^{VEAR}	3. TIME OF DEATH 0915
	4. SOCIAL SECURITY NUMBER 579-01-331	5	5. SEX 1 M 2 XF	6. AGE (In yrs. 8 3		IF UNDER 1		IF UNDER	R 24 HRS.	7. DATE OF BIRTH 1.0/06/1	913	Countr	PLACE (State or Foreign 1) 1rginia
OR	96. FACILITY NAME (II not institution 5408 Knoxy RESIDENCE OF DECEDE	11		е		9ь. СІТУ, 1 СО			Par.			ince	eath e George
DIRECTOR	10a. STATE 10b.	COUNT	nce Geo	rge	10c. Cl	TY, TOWN OR			Par	k			10d. INSIDE CITY LIMITS? 1 XES 2 NO
FUNERAL	100. STREET AND NUMBER 5408 Knoxy	i 1:	le Driv	е				074				S.Z	WHAT COUNTRY?
B	11. MARITAL STATUS 1 Never Merried 2 Merrie 3 Widowed 4 Divorced	d	12. WAS DECEDEN FORCES? IF YES, GIVE V	YES 24		H	yes, spec	ty Cub		NIC ORIGIN? (Specify Y in, Puerto Rican, etc.) y:	ea or No	14. RACI Blaci Spec	E American Indian, k, White, atc.
COMPLETED	15. DECEDENT (Specify only highe Elementary/Secondary (0-12)			P)	(Give kind of life. Do NOT (work done du work done du ise retired.)	ring most	of work		P.G.			Dept.
BE COM	17. FATHER'S NAME (First, Middle, L Joseph Gue		Lno					18. MOT	Bes:	ME (First, Middle, Maide sie Garr	n Surname) ett	Gue	rino
10 8	Nancy K. J		es (dau	ghter)	196. MAILIN 5	408	Street and	d Numbe	or Rural	Route Number, City or R Drive	Coll	2074	Park, M
	2017METNOD OF DISPOSITION 1 Buriel 2 Cremetion 3 4 Donetion 5 Other (Specific	Rem	oval from State	20b. PLAC other	place)	rahai	n Ce	eme	tery	y 0	ocation -	e, 1	7a.
	21. SIGNATURE OF FUNERAL SER	V.	Podd		6204	4.	00 1	wes	C Ma	eddy Fun ain St.	ora	nge,	, va. 22
	23. PART Enter the disease shock, or heart f. IMMEDIATE/CAUSE (Finel disease or condition resulting in deeth)	illure.	. Cor	glstv	re?	Hea	√ †		ailu		piratory ar	reat,	Approximata interval Betw Onset and Di
CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	{	G	(OR AS A CONS									
CER	PART II. Other significant co	L	d.	death hut se	1	In the unit			olice le	Seat Law und	IN AUTOPSY	lan	WERE AUTOPSY FINDS
PHYSICIAN: MEDICAL	PART II. Other significant co	IGITIO	a contributing to	- death but no	readiting	in the the	eriying	Cause	given in		ORMED?	246	AVAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?
CIAN	25. WAS CASE REFERRED TO MED EXAMINER?	CAL	HOSPITAL:			OTHER		VCE OF	DEATN (Ch	neck only one)			
	1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pendil		1 Inpatient 2 26e. DATE Of (Month,)		28b. TI		RBG. INJU WOR	IRY AT	ealdence	8 Other (Specify) 28d. DESCRIBE HOV	/ INJURY O	CCURED	
TED BY	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be		OF INJURY — At etc. (Specify)	home, farm	street, facto	ry, office			28f. LOCATION (Stree City or Town, Sta		er or Rural	Route Number,
COMPLETED	onel only									to the ceuse(e) end no time, date end place,			e) end menner as atate
H	296, BIGHRTUNE AND TITLE OF C	Q	Klu	MU	10			29c. LK	CENSE NU	MBER YZ	29d. DA	TE SIGNE	13 / 199
2	30 NAME AND ADDRESS OF PER	OH W	O COMPLETED CAS	OF DEATH O	7EM 27) (Typ	e, Print)		0	-	1 1		-0	MDZO:

31. DATE PILED (MOMIN, Cos), 1607) MAR 1 9 1997

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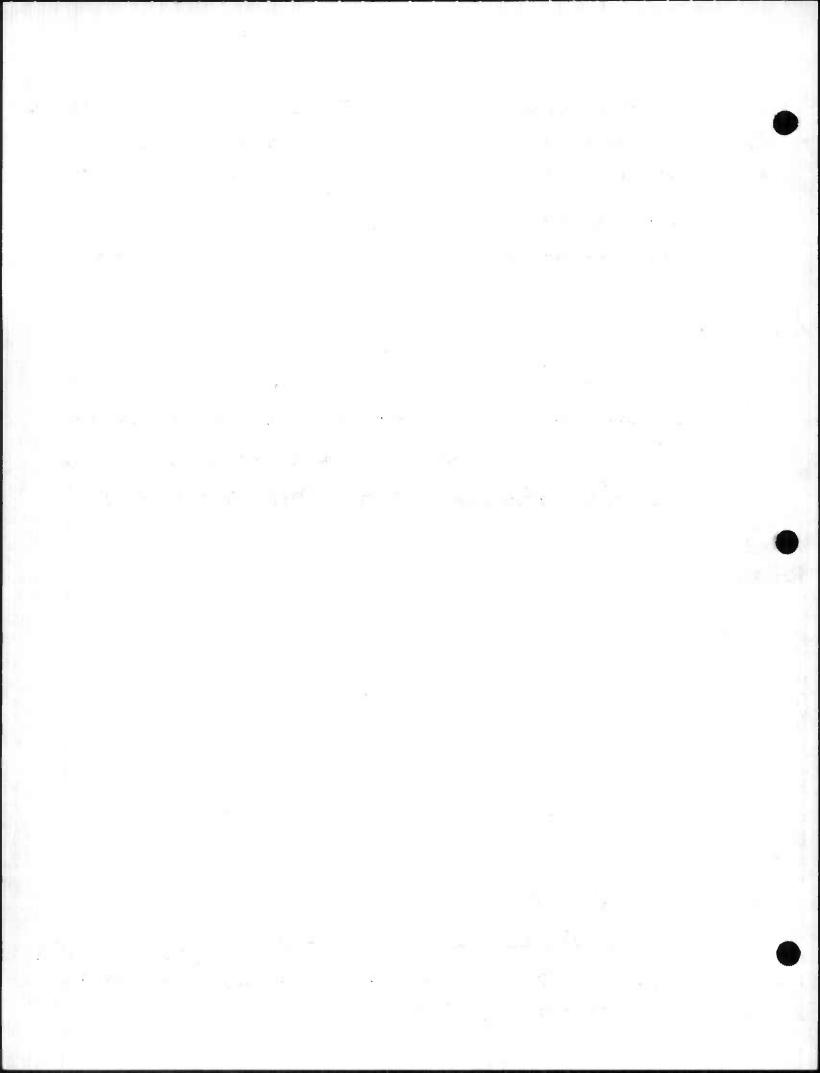


				State	or iviaryiar		tificate of		d Mental Hy		97	08305
Phys /Me	ician dical								2. Date of Do Month Februa	Dey	Year 1997	3. Time of Death 7:45AM
	niner		e (If not institution	give street end n	rumber)			4b. City, Town,	or Location of Dea			7.45111
Funer Direct		Manor (5. Sociel Security 189–18-		Omac 6. Sex 1□M 20XF	7. Age (In yrs. lest birthdey) If Under 1 Y			Potor If Under 24 H Hours M	Irs. 8. Dete of Bi in. (Month, D	rth ey, Year)	Montgomery 9. Birthplece (Sta Country) 24, 1922 Pennsylv	
2 .		Usual Residence								1, 1,22	Telli	.b) IValita
death with the Manyand ms 23s or 28s-f show craust be notified at	Director	10a. Stete	10b. County			ty, Town or Loc Washing	gton, DC				1	0d. Inside City Limits 1 Yes 2 No
10 S 20 S	Dir.	10e. Street end i					10f. Zip Code			10g. Citizen of	Whet Coun	try?
a 23a	<u>e</u>	2844	Wisconsi				2001			Unite		
5 22	by Funeral	3 ☐ Widowed	s arried 2 Marrie 1 4 Divorced	Armed F	2 No Sive	lf	Ves Decedent of F Yes, specify Cuba	lispenic Origin? an, Mexicen, Pu Specify:	(Specify Yes or No erto Rican, etc.)	Specif		
72 hour return!	ted .	(Sr	15. Decedent'	s Education	0	16e. Deced	ent's Usuel Occup	ation	working	16b. Kind of B		
vellting be Me	Completed	Elementery/Se	condary (0-12)	1	College (1-40r 5+)			uel Occupation ork done during most of working use retired) al Specialist		United Stat Government		tes
fland 2 lid be filed fental Hygi ked other fic event, ti	To Be	17. Fether's Nerr	e (First, Middle, L						Noust on i		ne)	
ary should man	-		Name/Reletionsh			19b. Meiling	g Address (Street		Kousteni Rurel Route Numb		State, Zip	Code)
re, Ma s t and 2 f Health a flem 27 is other tran		T.A. La		other	20h. F	218 K	Kent Oaks	Way, C	aithersb		rylan	d 20878
Pages nert of in		1 🕅 Burial	2 ☐ Cremation 5 ☐ Other (Sp		n State	semetery, crem	etory or other plea		1997			
# # # # # #	SUCE	21. Signeture of	Funeral Service L			831 22. Rob		ss of Fecility phrey Fun		Bethesda-	-Chevy	Maryland Chase, Inc.
-		23e. Part1. Ente	r the dispase, of o	omplications that	ceused the deat				Bethesda,		20814	Approximate
Physicia /Medica Examine	al	Immediate Cause (Final									I month	
E LEWIN		Toobking in door	',		Due to (c	or es a consequ	uence of):					
68760, ficete be executed physician end st the bunel-transit	Examiner	Sequentielly list if any, leeding to	conditions,	b	Due to (c	er es e consequ	ience of):		1	9	-	
68760, ficete be ex physician is the buriel		ceuse. Enter Un Cause (Diseese thet initiated ever	derlying or Injury	C	1955							
	Medical	resulting in deeth		d.	Due to (o	r as a consequ	ence of):				1	
deeth certi	clan	,										
that the edby the detech	y Physician/M	Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.						23b. Did tobacco use contribute to the cause of deat 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknot				
JIVISION OT VITAL HECONDS, or Attending Physician: The law requires the after death. Director: After this certificate has been signe i in by the funeral director, page 2 should be or	Completed by						4		24e. Wes	an autopsy ormed?	eve	re autopsy findings ilable prior to apletion of ceuse leeth?
The large page	Con								10	Yes 2⊠No	10	lYes 2□ No
r VITAL I	Be	25. Wes cese ref examiner?	erred to medicel						eeth (Check only	one)		
or vehysle	2	1 Yes 2			1 Li Inpatient 2 LER/Outpetient 3 Li DOA 4 La Nursing Ho					ome 5 ☐ Residence 6 ☐ Other (Specify)		
VISION OF VITA Attending Physician: or death. betor: After this certific by the funeral director,	Certification:	1 Netural 2 Accident			28e. Dete of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury et Work? 1 □ Yes			ret 28d. Describe (? Yes 2 □ No		be how Injury occurred		
DIVISION Attended in Director:	Certific	3 Suicide 4 Homicide	6 ☐ Could no determin	ad 289. Piec	e of Injury - At he ling, etc. (Specify	ome, farm, stree	et, fectory, office	\	28f. Location (City or To	Street end Numb wn, Stete)	er or Rural	Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edicai	29a, Certifier (Check only one)	1 X Certifying 2 Medical E	caminer: On the b	e best of my know easis of exeminal ener stated.	wledge, death of the tion end/or investigation	occurred et the timestigetion, in my o	e, date end ple binion, death oc	ce, end due to the curred et the time,	ceuse(s) and ma date end plece,	anner es ste and due to	eted. the cause(s)
To the To the	×	29b. Signature ar	d title of certifier	0111	0		29c. License	number		29d. Date signe	d (Month, E	Pay, Year)
		30 Name and of	whal	M	adly	220) /7:	D38	781		Februar	y 27,	1997
9			J. Grad	ly, M.D.	4910 M	assachu		venue, N	N.W., #31	2, Wash	ingto	n, DC 20016
S	tate	31. Dete filed (Mo		32. F	Registrer's Signe	ture	97					



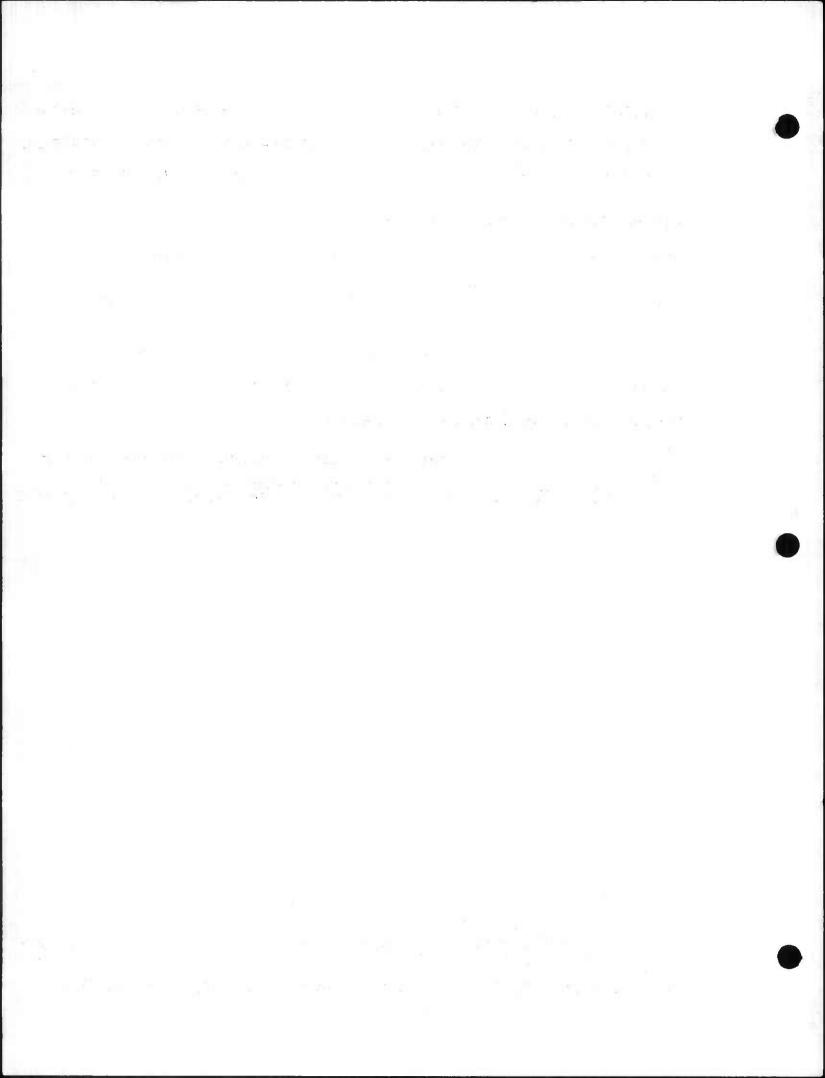
Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physicia		1. Decedant's Nama (First, Middla,					2. Date of De Month		3. Time of D	
/Medic		MILA	RED		CET	000	Feb.		1997 10-1	
Examin		4a. Facility Nama (If not institution,	giva streat and numbe	r)	4b. City, Town,		Location of Dear	th 4c. County of	Death	
		15548 PRINCE FR	EDERICK WAY	Y		SPRING MONTGOMERY		MERY		
uneral			. Sax 7. A	ga (In yrs. last b	pirthday) If Undar 1 Yas	r If Under 24 Hr	s. 8. Date of Bi		9. Birthplece (Steta or F Country)	
irector		085-38-6031 Usuel Residence of Decadent	10 M 20 F	85 Yrs. Months Days Ho		s Hours Min	Hours Min. (Month, Day, MAY 2, 1			
show	or	10a. Stata 10b. County		10c. City, Town or Location				10d. inside City L 1 ☐ Yas 2		
28a-f sh notified	Director	MARYLAND MONTGO 10e. Streat end Number	DMERY	SILV	ILVER SPRING 10f. Zio Coda			40.00		
5 8	ä						10g. Citizen of Whet Country?			
s 23s matt	gra	15548 PRINCE FR	1		If Yas, specify Cuban, Mexicen, Puant 1 Yas 2 No Specify: 16a. Dacedant's Usual Occupation (Give kind of work dona during most of worlifa. DO NOT use ratired)			UNITED STATES		
ar, or items Examiner m	by Funeral	11. Marital Status 1 Navar Marriad 2 Marrie 3 Widowad 4 Divorcad	12. Was Decedan Armad Forces 1 Yes 2 It Yas, Give Yaar or Datas	? KNO			(Specify Yes of No- arto Rican, atc.) 14. His		laca - Amarican Indian, Ilack, Whita, etc.	
natural disal Es	be	15. Decedent's	Education	16				16b. Kind of Business/Industry		
than "n	Completed	(Specify only highast Elamantery/Secondary (0-12)	grada com <i>plated)</i> Collega (1-4or	5+)						
nt, 1	Ö	12 17. Fathar's Nama (First, Middla, La	st)		HOMEMAKER	18. Mother's Nama (First, Middle		OWN HOME		
	Be							, wooden Sumama)		
8.8	2	DAVID GOLDSTEIN				ANNA				
100		19a. Informant's Name/Ralationship			19b. Mailing Addrass (Street and Number or 1506 CRESTLINE ROAD,					
Item 27 other tr		ALAN LETOW (SON)				NE KOAD,				
or of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3	☐Ramoval from State		of Disposition (Name of ary, cramatory or other p	(eca)	Data	20c. Location - Ci	ity or Town, Stata	
Important: If any injury or once.		4 Donation 5 Other (Spe		MOUNT	UNT LEBANON CEMETERY		2/28/97	ADELPHI, MARYLANI		
aminer	Examiner	diseas or condition rasuling in death) Sequentially list conditions,	a. Due to (or as a consequence of): Dua to (or as e consequence of):							
al-tran	ă I	if any, laading to Immadiata			consequance of):					
g physicia as the bur	edical	Sequantially list conditions, if any, leading to Immadiate causa. Enter Underlying Causa (Disassa or Injury that Initiated events rasulting In death) Last	c	Dua to (or as a	consequence of):		-			
g physicia as the bur	edical	rasulting in death) Last			consequance of):	in h Bad	and Did			
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or: After this certificate has been signed by the attending physicia the funeral director, page 2 should be detached for use as the but	Medical Certification: To Be Completed by Physician/Medical	25. Was casa rafarred to medical exeminar? 1	Hospital: 1 Inpat 28a. Date of Inj (Month, Do 28a. Place of Inbuilding, a	iant 2 ER/Cury 28b. iyury - At homa, 1 tc. (Spacify) of my knowledge of axamination a lated.	outpatient 3 DOA Injury M 15 Iarm, streat, factory, office and/or investigation, in my	26. Place of De wher: 4 \(\text{Nursing I} \) ury at ork? \(\text{Yas} \) 2 \(\text{No} \) tima, date and place opinion, death occording.	24a. Was performed at the time,	Yes 2 No sen autopsy primed? Yes 2 No ona) Idanca 6 Other how Injury occurred Street and Number win, Stata) causa(s) and mann dete and placa, end	24b. Ware autopsy find available prior to completion of caus of daeth? 1 Yas 2 No (Specify) or Rural Routa Number are as steted. d dua to the ceuse(s)	



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time u Counth **Physician** 1997 DOROTHY MARCH 6:43pm LEAGUE /Medical 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COMMUNITY LANHAM-SEABROOK PRINCE GEORGE'S CO. DOCTORS HOSPITAL If Under 1 Yaar Months Days If Under 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Oct • 3, 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foreign Country) Maryland **Funeral** Days 83 Yrs. 214-03-4561 Director Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits r 28a-f show the Maryla Maryland Prince George's 1 Yas 2 XX Director Lanham 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? than "natural", or items 23a or the Medical Examiner must be 20706 United States 6803 Trexler Road Funeral 12. Was Decedent Evar In U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-It Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 11. Maritai Status filed within 72 hours after Hygiene. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 White 1 Yas XX No by 3XXVidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) Eiamantary/Secondary (0-12) Coilaga (1-4or 5+) Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Meldan Sumama) Be should be and Mental Miller Lillian Carlisle is marked Walter ို permit. Pages 1 and 2 sh Department of Hestith and Important: if them 27 is me any injury or 19a. Intormant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Steta, Zip Coda) Francis Douglas League, Jr. (son) same as #10 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data Weurlal 2 ☐ Cramation 3 ☐ Ramoval from State 3/5/1997 Druid Ridge Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 20 Name ind Address Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death Physician immediata Causa (Final disaasa or condition rasulting in death) /Medical Examiner Examiner certificata be axecuted attanding physician and for use as the burial-transit Sequentially list conditions, if eny, leeding to Immadiate ceusa. Entar Undarlying Cause (Diseese or injury that Initiated avents rasulting In death) Last Box 68760. Physician/Medical Part II. Other algniftcant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? tha detached ned by 1 Yes 2 No 3 Probably 4 Unknown by 500 24a. Was an autopsy performed? 24b. Wara autopsy findings availabla prior to compiation of causa of daath? Completed peen has 1 □ Yas 2 19 No 1 Yas 2 No 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) P 1 Yas 20 No 1 Inpatiant 3□ DOA 2 ER/Outpatient this funaral 28a. Deta of Injury (Month, Dey Year) 27. Magno of D of Death 28c. tnjury et Work? 28d. Dascribe how Injury occurred Certification: Aftar To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 5 Pending Invastigetion 1 Yas 2 No 2 Accident tha Could not be datarminad 3 Sulcida 28e. Plece of Injury - At homa, farm, streat, tactory, office building, atc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, Stata) filled in by 4 Homicida edical 29a. Certifia: 1 Certifying Physician: To tha best of my kpowledge, deeth occurred et tha tima, data and piace, and dua to tha ceusa(s) end mannar as stated. complately Medicat Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) D05401 30. Name addrass of person who complated ceuse of deeth (Item 23a) (Typa, Print) James Hardy, 7525 Greenway Center Drive, Suite 316, Greenbelt, MD 20770 31. Data fliad (Month, Day, Year) 32. Registrar's Signature State MAR 0 4 1997 Mia Davidson Registrar

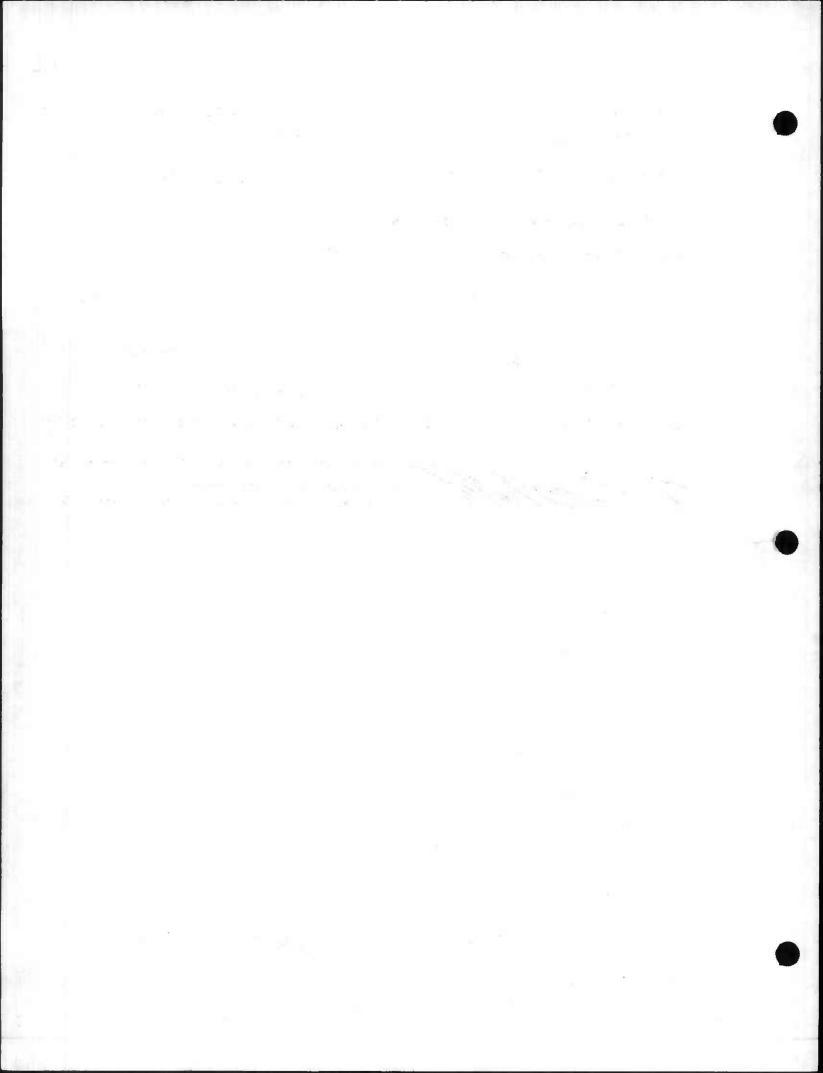


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath **Physician** Month Wu-Wei LI March 3, 1997 /Medical 11:15 PM 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Sacurity Number If Under 1 Year If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1 ☐ M 2 ☐ F Hours Director 84 Yrs. 058-26-8557 March 12,1912 China 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show must be notified at 1 ☐ Yas 2 ☐ No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Coda 10g, Citizan of What Country? ò 20902 USA Herrie 23a 11312 College View Drive 12. Was Decedant Evar in U.S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, GiveXX Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 1 Navar Married 2 M Married Baltimore, Maryland 21215-0020 ò 1□ Yas 2□No Àq Specify: 3 Widowad 4 Divorced Asian natural. Completed 15. Dacedant's Education (Spacify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Hygiece. Elamantary/Secondary (0-12) Collaga (1-4or 5+) Radio News Editor 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Important: If Item 27 is marked of any Injury or other tree Be 9 Chang Nai Li -unobtainable - Chen 19a. Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 11312 College View Drive, Silver Spring, MD 20902 Betty Wong Li (Wife) 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 XBurial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Spacify) Gaze of Heaven Cemetery 3-7-97 Silver Spring, MD 21. Signature of Funaral Service Licensaa 22. Nama and Addrass of Facility
Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batwe Onsat and Daath Physician Immediate Cause (Final disease or condition resulting in death) toomen Examiner na Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to (or as a consaquance of): Box 68760, Physician/Medical Dua to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobscco uss contribute to the cause of desth? 1 Yss 2 No 3 Probably 4 Unknown Records, à 24b. Wara autopsy findings avsilable prior to Completed 24a. Was an autopsy performed? completion of ceuse of daath? The law 1 Yas 2 No 1 Yas 2 No of Vital or Attending Physician: Be 25. Was cesa rafarred to medical 26. Placa of Death (Check only ona) Hospital: Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) To 1 Yas 2 No Inpatiant 2 ER/Outpatient 3 DOA 27. Mannar of Daath 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred Division 5 Panding Invastigation 1 Natural death. 1 Yas 2 No 2 Accidant after death 6 Could not ba datarmined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) filled in by 4 ☐ Homicida within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifian completely (Check only one) \$ 29b. Signatura and titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) recenval SILVER SPRING, MA 30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) N. HARR M.D MEDICALPARK DR. 20902 1997 Julia Davidson Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 08309 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** ESTHER FEBRUARY 27, 1997 cation of Deeth 4c. County of Death /Medical 4e. Fecility Neme (ff not institution, give street end number 4b. City, Town, or Location of Deeth **Examiner** Takoma Park Washington Adventist Hospital Montgomery If Undar 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number 7. Age (In yrs. lest birthday) 6. Sex Birthpiece (State or Foreign Country) 1□M 2⊠F Yrs. 579-36-2084 May 30, 1911 Missouri Usuel Residence of Decadent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Maryland | Prince George's College Park 10f. Zip Code 10g. Citizen of Whet Country? 7401 Dartmouth Avenue Funeral 20740 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Reca - Amarican Indien, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 1 Nevar Married 2 Married 1 ☐ Yas 2 ☒ No Specify: by Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Fether's Name (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meidan Sumame) Be 10 Edward Perry Elizabeth Reynolds 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Jimenez 5406 Knoxville Drive College Park, Maryland 20740 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, crematory or other piece) Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Crametion 3 ☐ Removal from Stata 4 Donetion 5 Stother (Specify)Entombusent Gate of Heaven Cemetery 3/03/97 Silver Spring, Maryland 22. Name end Address of Facility Francis J. Collins Funeral Home, Inc. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrast, or heart failure. 500 University Blvd., W., Silver Spring, MD 20901 Approximete Intervel Between Onset end Deeth SPIRATION PNEUMONIA mediate Cause (Final Weeks disease or condition Due to (or es a consequence of) Examiner EMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or es e consequence of) AGE Physician/Medical Due to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DI Scarp by 24b. Were autopsy findings available prior to completion of cause of deeth? Be Completed 24a. Was en eutopsy performed? ULCER 2 X No 1 🗆 Yes 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28c. injury et Work? 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending invastigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) Location (Street end Number or Ruraf Route Number, City or Town, Stete) 4 ☐ Homicide 29e. Certifier Medicai 1) Certifying Phyelcien: To the best of my knowledge, deeth occurred at the time, data and pleca, end due to the cause(s) and menner as stated.

2 Medical Examine: On the basis of examination and/or investigation. In my opinion, death occurred at the time, data and place, and due to the On the basis of examinetion end/or investigetion, in my opinion, death occurred at tha time, date and piece, end due to the ceuse(s) end manner steted. 29b. Signature and tigle clicertific 29c. License number 29d. Dete signed (Month, Dey, Year)

The law requires that the deam certificate been signed by the a should be detached of Vital Records, certificate or Attending Physician: this filled in by the funeral After Division To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: A completely

P.O. Box 68760,

Funeral

Director

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Important: If Item 27 is m any injury or other traum once.

Physician

/Medical

Examiner

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Pages 1 and 2 should be nent of Health and Mental

Baltimore, Maryland 21215-0020

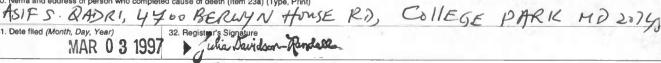
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The Medical

State Registrar

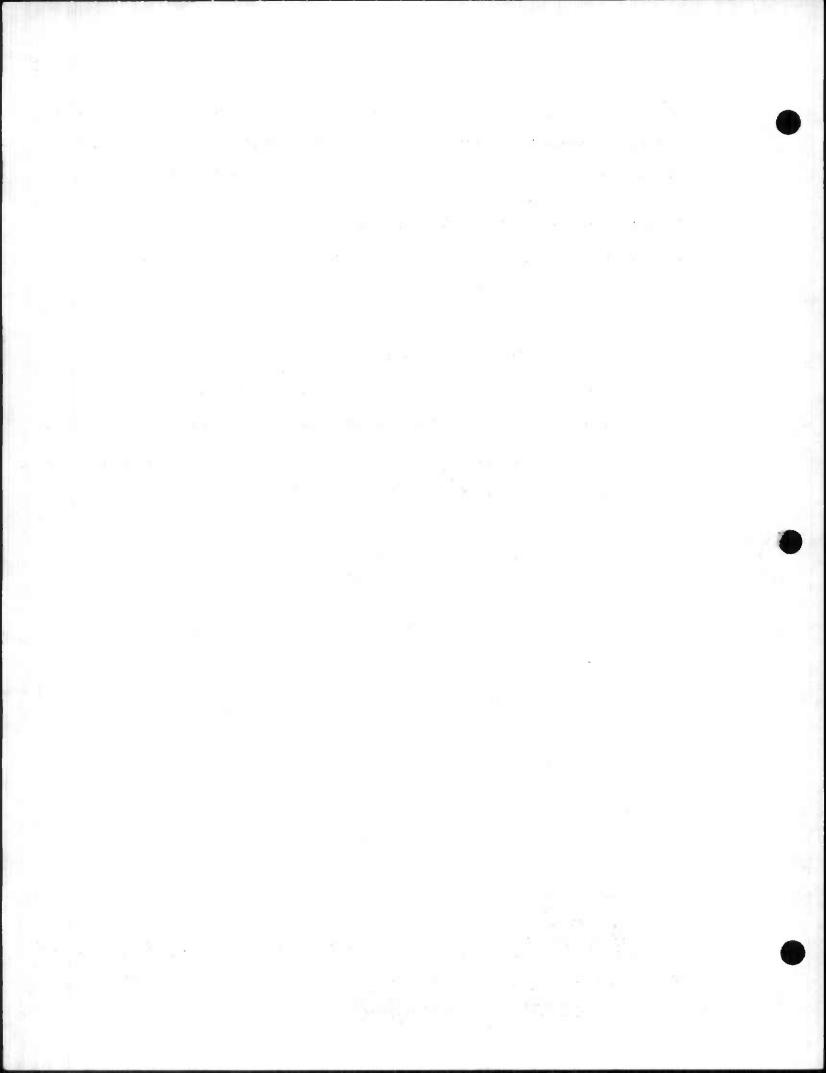
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30. Nema and eddress of person who completed cause of deeth (Item 23a) (Type, Print)



D22910

2Feb: 28tt, 1914.



State of Maryland / Department of Health and Mental Hygiene Items: 23 part I,27 per MEO G-745 3/21/97 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Deeth Month Vaar **Physician** SHERMAN 1997 /Medical LUCAS MARCH 8:05P.M. 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 8. Data of Birth (Month, Day, Y Feb. 10, if Under 24 Hrs. Hours Min. 9. Birthpleca (Stata or Foreign Country) Alabama 5. Social Sacurity Number if Undar 1 Year 6. Sax 7. Age (In yrs. lest birthdey) **Funeral** Days 1□M 2\F Months 061-46-0092 44 **Director** Usual Rasidance of Decedent the Marylend 10e. State 10c. City, Town or Location 10b. County 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryle Department of Health and Mental Hyslene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any fujury or other traumatic event, the Medical Examiner must be notified at once. Prince Georges 1 Yes 2 □ No MD Landover Hills Direct 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 7509 Buchanan Ave., #316 20784 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puarto Rican, atc.) 1 □ Never Married 2 □ Married 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: Baltimore, Maryland 21215-0020 Black 1 ☐ Yas 2 ☐ XNo Specify: þ 3 Widowad 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) Law Office 4 yrs Legal Secretary 17. Fethar's Nema (First, Middla, Last) 18. Mother's Neme (First, Middla, Meiden Surnama) Louise Sherman Herman Manley 2 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Herman Manley (Father) 59 Urban Street, Buffalo, NY 14211 20b. Place of Disposition (Nama of cematery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2CC ramation 3 ☐ Removal from Stata 3/7/97 Alexandria, VA 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Crem. Signatura of Funaral Sarvica Licans 22. Name and Address of Facility
SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 23a. Part 1. Entar the disaasa, or conshock, or haart failura. List on plications that caused tha daath. Do not enter the mode of dylng, such as cardiac or raspiratory arrast, ona causa on aach lina. Approximate interval Betw Onset end Death Physician /Medicai Immadiata Causa (Final PULMONARY EMBOLUS disease or condition rasulting in death) Examiner Due to (or as e consequança of): Examiner that the deeth certificete be executed physiclan end the burial-transit Sequantially list conditions, if eny, leading to Immadiata causa. Entar Undarlying Ceuse (Disease or Injury that initieted avants rasulting in death) Lest Dua to (or es e consequença of): P.O. Box 68760, Physician/Medical Due to (or es e consequance of) 88 980 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24a. Was an eutopsy performed? 24b. Wara autopsy findings evailable prior to Completed peed completion of causa of death? page 2 s 2 No certificata Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifical funeral director, Be 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 2 1 XYes 2 No Mnpatiant 2 ER/Outpetient 3 DOA 27. Mannar of Daath 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: 5 Panding invastigation 1XX Natural 1 Yas 2 No 2 Accident 6 Could not be datarminad 3 Suicida 28f. Location (Straet end Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homloide 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, deeth occurred et tha tima, data and place, and due to the cause(s) and mannar as stated. Medical 2 Madical Examinar: On the basis of examinetion and/or invastigation, in my opinion, death occurred at tha tima, data and placa, and dua to the cause(s) end menner steted. To the vithin 2 29b. Signatu nd title of certified 29c. License number 29d. Date signed (Month, Day, Yaar) O.C.M.E. MARCH 3,1997 addrass of person who completed causa of de th (Itam 23a) (Type, Print) 15 LARON 111 Penn Street, Baltimore, Maryland 21201 31. Data filed (Month, Dey, Yaer) 32. Ragistrar's Signatura State

DHMH 16 Rev 6/95

Registrar

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Tia Davidson

P.O. Box 68760, Records, Division of Vital

Maryland 21215-0020

altimore.

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Pages 1 and 2 should

The law requires that the death certificate be executed certificate has or Attending Physician: this After t To the Hospital or Attendin within 24 hours after death.

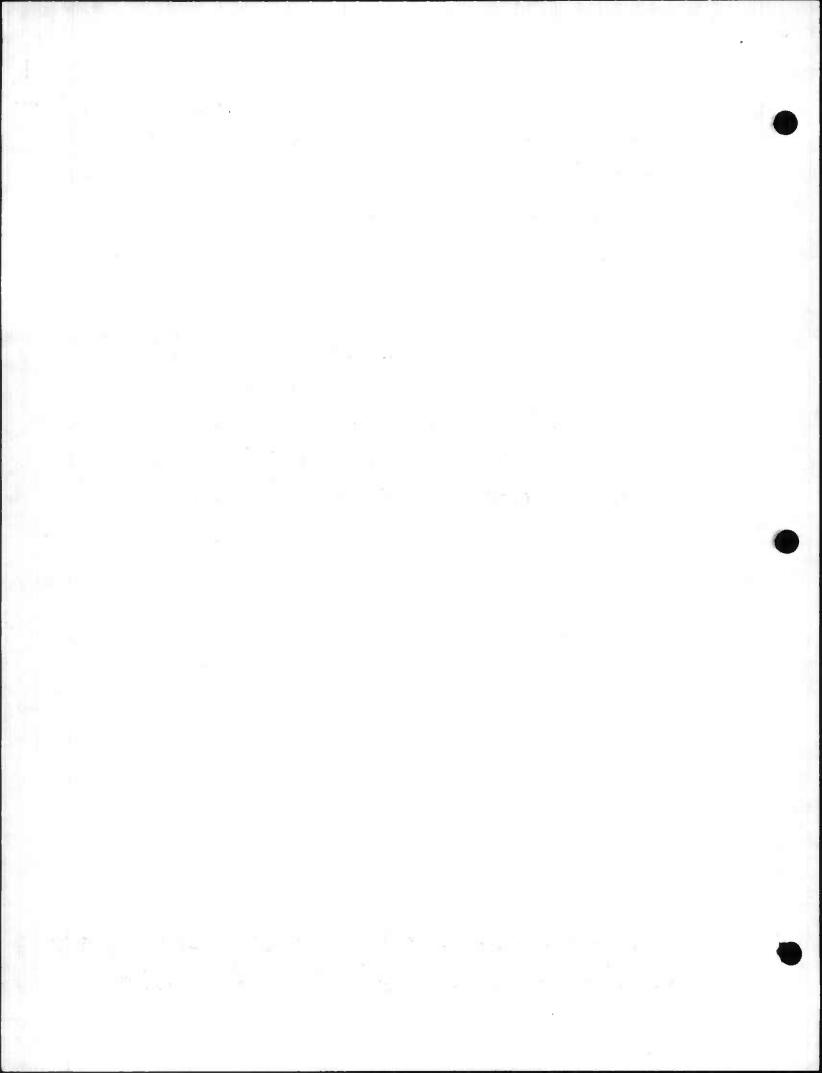
To the Funeral Director: Aft completely filled in by the fun death.

Certification: 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the lime, dete end plece, end due to the cause(s) end menner es steted.
2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner steted. Medicai 29a. Certifier (Check only one) 29b. Signeture end little of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D34385 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) GEORGE S. FROMAN NORTH DRIVE COLUMBIA,

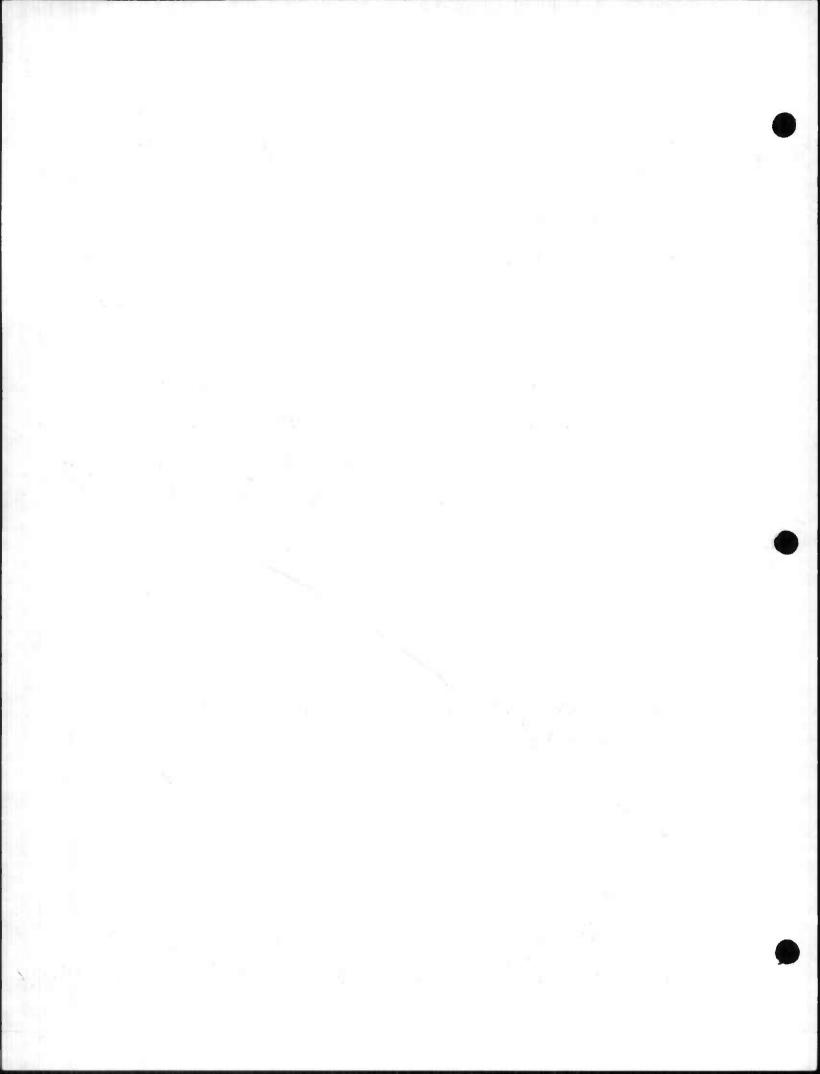
State Registrar

32. Registrer's Signeture

DHMH 16 Rav 6/95



							001	inicate o	Doan	1		Reg. No.		
	Physic		1. Decedent's Neme (First, Middla, Last) Helen Dorothy Lynch								2. Date of De Month Januar	peth Day	Yeer 997	3. Time of Deeth 12:37AM
) v	/Medi Examir								own, or Lo	ocation of Deet			12.3/AFI	
										esda		Mont	gomer	У
	Funeral	Г	5. Social Security N		Sax I□M 2XXF	7. Age (In yrs.		If Undar 1 Yas Months Day		r 24 Hrs. Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Birth	plece (Stete or Foreign
e .	Director		315-12-6 Usuel Residence of	138	ZADA	72	Yrs.					, 1924		sylvania
	/land		10a. State	10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	Man B-f sh	tor	Maryland	Montgome	ery	Betl	hesda							1 ☐ Yes 2 X No
	or 28	Directo	10e. Street and Nur	mber				10f. Zip Code			T	10g. Citizen of Whet Country?		
	23a	rai	7420 Lakeview Drive, #206 20817								United	Stat	es	
	terns ver m	Funerai	11. Marital Status		Armad For	ces?	If Yas, specify Cuben, Mexican, Puarto				ecify Yas or No Rican, etc.)	- 14. Rad Ble	ca - Amari ck, White,	can Indien, etc.
21215-0020	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at ance.	by	1 Never Marri	ied 2 X Married 4 □ Divorcad	1 Yes If Yes, Give Year or Da	8	1	□Yes ŻŒN	o Specify	y:		Specif	y. Whi	.te
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Maryland	mer mer	F	19a. Informent's Na				19b. Meilin	g Address (Stre	et end Numi		,		,	Code)
Σ	alth a		James Wal	ter Lyncl	h/Husban	ıd	7420	Lakevie	w Dri	ve,	#206, B	ethesda	, Mar	yland 20817
ore	of He		20e. Method of Disp	oosition XCremetion 3	ID	20b. P	iece of Dieno	sition (Name of netory or other p			Data	20c. Location		
Ĕ	Pag ment ant: If ury o			5 Other (Specif		Mo	ntgome	Jan ry Crema	uary itoriu	16, I	199/ nc.	Bethes	da, M	[aryland
Baltimore,	Departi Departi import any inj once.		21. Spature of Fu	neral Service Licer	abol .							Pumphr	ey Fu	neral Home
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			23e. Pert1. Enter ti shock, or hee	he disease, or com rt feilure. List only	plications that ca one ceuse on ea	used the deeth ach line.	n. Do not ente	er the mode of d	ying, such a	s cardiac o	or respiretory a	rrast,	1	Approximata Interval Between
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	Examiner		diseese or condition resulting in deeth)		e. 1/E	3110	AINK.	1 FAI	LUKI	ヒ				
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	certificate be executed Iding physician end Ise es the burial-transit	Examiner	Sequentially list co	nditions,	b		es e conseq		(1.0			JUNE		
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387	physi s the	dic	that initiated events resulting in death) i	Last		Due to (or	es e consequ	uenca of):						
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	law requires that the death les been signed by the etter s 2 should be detached for u	sicia	Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I.							1	23b. Did	tobacco usa co	ntribute t	n the cause of rieath?
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Division of Vital Records,	w requires that been signed be should be det	Completed	BROM	SCHIT	15						24a. Was perfo	en eutopsy med?	av	ere eutopsy findings allable prior to
Sec.	hes b	npie											of	mpletion of cause deeth?
<u>e</u>	: The cete h										10	Yas 21 No	1 [☐ Yes ZXNo
<u> </u>	iclan: The certificate rector, pag	o Be	25. Was case reference examiner?		Hospitel:				ther		h (Check only o	-		
o	Attending Physician: or death. ector: After this certific by the funeral director,	-	1 ☐ Yes 2 ☐ 27. Manner of Deet		1 LI In		ER/Outpetien 28b. Time of	3 DOA	4 L N			dence 6 □Oth how Injury occur		(y)
on	nding tth. : Afte e funt	ation	1 Natural 2 Accident	5 ☐ Pending investigation	28a. Date of (Month)	n, Day Year)	Injury	28c. Inj W M 1	ork? ⊒Yes 2□					
VIS	i or Attending lefter death. Director: After in by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	288. PIECE (of Injury - At ho g, etc. (Specify	me, farm, stre	et, factory, office	θ		28f. Location (ber or Run	el Route Number,
٥	rs effer sl Direction by	Cer	4 El Homoldo		Dullari	д, өкс. (Эрөсну	<i>'</i>				Oily of 10	wii, State)		
	To the Hospital or Attending Physician: The is within 24 hours effect death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai	29e. Certifier (Check only one)	Certifying Ph 2 Medical Exam	ysicien: To the b niner: On the bas end mann	sis of exeminet	wledge, death Ion end/or inv	occurred et the estigation, In my	time, date e opinion, de	nd place, eth occurr	and due to the red at the time,	ceuse(s) end m dete and piece,	anner es s end due t	tated. the ceuse(s)
	To the To the	Me	29b. Signeture end	title of entitler	Λ			29c. Lice	nse number			29d. Date signe	d (Month,	Dey, Year)
				Try 1	1/1 . 1	-		1)7	65	71		1/1	5/9	77
			30. Name and address	ass personwho	completed gayse	death (Item	23a) (Type, I	Print) M. C	1 2.	44	AVE	Reni	ecol	LMDTAR
	5 Sta	te	31. Deta filed (Mont			gistrer's Signer	ture -	5000	LN	3 (/	JVZ	חושנו	~ V).	1000
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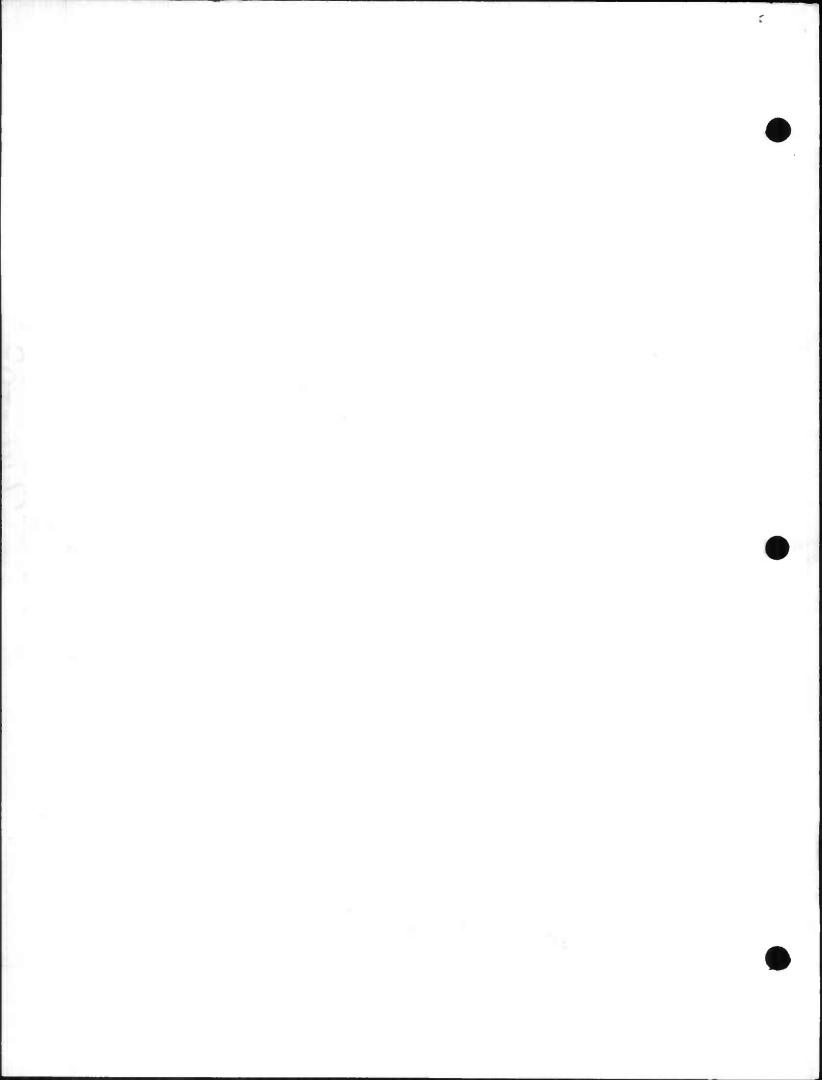
DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

13 8 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE OF DI				3. TIME OF DEATH	1	
			Agnes M.	Lawler						March	06,	06, 1997 2:29			рм	
	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs. la:	st birthday)	IF UNDER		IF UNDER	7	7. DATE OF BI	ятн			IPLACE (State or For	wign .	
	084-10-9183	3	1 🗆 M 2 🔀 F	84	YRS.	MONTHS	DAYS	HOURS	MIN.	Nov 21	, 19	New York				
ŀ	9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CITY, TOWN OR LOCATION OF DEATH						9c. COUN	UNTY OF DEATH			
DIRECTOR	Anne Arunde		ical Cent	er		Anr	napo	lis				Anne Arundel				
<u> </u>	10a. STATE	10b. COUNTY	1		10c. CIT	Y, TOWN	OR LOCA	ION						10d. INSIDE CITY	111	
ä	New York	Queer	าร		For	rest	Hil	ls						1 X YES 2 1	NO	
AL	10e. STREET AND NUMBER						10	. ZIP COD	E			10g. CITI	ZEN OF V	VHAT COUNTRY?		
EB	193 Puritar	Avenu	ae					1137	5			USA				
FUNERAL	11. MARITAL STATUS			T EVER IN U.S. AF						IIC ORIGIN? (Spen,		r No—	14. RACE	— American India	n,	
ВУ	1 Never Married 2 3 Wildowed 4 Divo		IF YES, GIVE					2 X NO			410.1	- 1	Spec	White		
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2	Grade 12)-12)	College (1-4 or 5	+)						Tnau	****					
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	Peter McDor								cv Hy	_ , _ , , _ , ,	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,,,				
BE	19a. INFORMANT'S NAME (7			19	b. MAILING	ADDRES	S (Street a			Route Number, Cit	ty or Town,	State, Zip	Code)	07.4	107	
2	Thomas P. I	awler		son	401 :	S Che	errv	Gro	ve Ar	zenije,	Annai	noli	s. N	214 Maryland	TOT	
	20a. METHOD OF DISPOSIT	ION		20b. PLACE	AND DATE	OF DISPOS	SITION /N/	ame of								
	1 Burtal 2 Crematic		oval from Stata	St. C	harl	es C	emet	erv		3/10						
ļ	21. BIONATURE OF FUNERA	L SERVICE LIC	ENSEE	/		22.	NAME A	ND ADDRE	SS OF FA	CILITY						
	D & 66/1	4 /	& help	-		1				eral Ho				2 20707		
	23. PART I, Enter the d	Mahaus, or o	complications the	it caused the d	eath. Do									Approxima	ta	
	shock, or h	eart failure.	List Dniy Dne ca	use on each iln	e.	P			K					Interval Be	tween	
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CERTIFICATION	Sequentially list condit if any, leading to imme	OR AS A CONSE	QUENCE O	9		-	and	1-6-1				77				
CA	cause. Enter UNDERLY CAUSE (Disease or Inju				-											
F	that initiated events	T .	DUE TO	(OR AS A CONSE	OUENCE C	F):										
H	resulting in death) LAST															
	PART II. Other significa	nt condition	s contributing to	death but not	resulting	In the u	nderlyin	g cause	given in	Part I. 24a.	WAS AN AL		248	. WERE AUTOPSY FIR		
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M	25. WAS CASE REFERRED T EXAMINER?	O MEDICAL		26. PLA	CE OF DEA											
Sic	1 YES 2 NO		HOSPITAL:	ER/Outpetlant	3 DOA	4 Nu		ne 5 🗆 R	asidenca	6 Other (Spe	cify)					
PHYSICIAN:	27. MANNER OF DEATH	2020-0111	28a. DATE Of (Month, i	F INJURY Day, Year)	26b. TII	ME OF JURY		JURY AT		28d. DESCRIB	E HOW INJ	JURY OC	CURED			
ВУ		Pending investigation				М		YES 2	NO							
	3 Suicide 8 Homicide	Could not be determined		OF INJURY — At h., etc. (Specify)	ome, term,	atreet, fec	tory, offic	a		28f. LOCATION City or You		d Number	or Rural	Route Number,		
	4 Homicide	Getermined														
7		TIFYING PHYS	ICIAN: To the best o	f my knowladge, d	eath occur	red at the	time, data	end plac	e, and due	to the cause(s)	end manne	er as stat	led.			
COMPLETED	one) 2 MED	ICAL EXAMINE	R: On the besis of	examination and/or	Investigati	on, In my	opinion,	death occu	red at the	time, data and p	place, and	dua to th	e ceuse(s) and manner as st	ated.	
BE C	296. SIGNATURE AND TITLE	OF CENTURE	7	10	- 1			29c. LIC	ENSE NUI	MBER		29d. DAT	E SIGNED	(Month, Day, Year)		
TO B	11.4 94	sola	udu	la				10	5/4	12		13	161	197		
-	30. NAME AND ADDRESS O	F PERSON WH	O COMPLETED CAU	SE OF BEATH (ITI	EM 27) (Typ	e, Print)	1		A	Λ		10	10	-11100		
	Kichard -	LITTO	hman	·WID	183	3A	10	451	UF	Hnn	2100	45	nec.	2140		
	31. DATE FILED (Month, Day,	ardelle					,	/	(,					
	MAR (7 199	1													



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Daath **Physician** Month Peter James La Monica March 1997 7:00 AM /Medical 4b. City, Town, or Location of Daath 4e. Facility Nama (If not institution, give street and number, 4c. County of Death Examiner Mc Cauley Acres Cecil If Under 1 Year If Under 24 Hrs. 8. Data of Birth
Months Davs Hours Min. (Month, Dey, Year) 5. Social Security Number 6. Sax 7. Aga (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Vrs 046-16-8384 Director Marh 22, 1922 Usuel Residence of Decedant 10e State 10b. County 10c. City, Town or Location 10d, Inside City Limits EIKtON 1 Yas 2 No Cecil Director Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zlp Code b Acres 15 MC USA Herrs 23s 21921 Caule. 12. Was Decedent Ever In U.S. Armed Forces? 13. Was Dacedanf of Hispanic Origin? (Specify Yas or No-If Yes, apecify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, efc. 11. Marital Stetus Armed Forces?

1 Yes 2 No WW II
If Yes, Give Koreun
Yaar or Dates: V. et Num 1 ☐ Never Merried 2 ☑ Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specity: White þ 3 Widowed 4 Divorced Completed 18e. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) College (1-4or 5+) au Sevior Chief Medical Corpsman permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: If Item 27 is marked other th any injury or other traumeric event. 12 18. Mother's Name (First, Middle, Meiden Sumema) 17. Fether's Nema (First, Middla, Last) Rose Belardi Francis La MONICA 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 78 LINCOLN AVE NOrth East MO. 21901 Francis Michael La Monica - SON 20b. Plece of Disposition (Neme of cemetary, crametory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from Stete 3/13/97 R.A. Ferris + Co., Ix. Crem. West Chester, P.A. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature di Service Licensee 22. Nama and Address of Facility Gee Funeral 259 E. Main St. ElKton, mD. 2192 23a. Pert1. Enter the dressa, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting In deeth) /Medical Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseese or Injury thef Initiated events resulting in daeth) Last Box 68760. Physician/Medical Due to (or es a consequance of): Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed certificate 1 ☐ Yas 2 ☐ No 1 ☐ Yes 2 ☐ No f or Attending Physician: efter death. Director: After this certifica 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred Certification: 28b. Time of 5 Pending Invastigetion 1 Netural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datamined To the Hospital or Atter within 24 hours efter der To the Funeral Director completely filled in by th 3 Sulcide 28e. Place of Injury - At home, farm, atreet, fectory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Steta) 4 Homleide edical Certifying Phyalcian: To the best of my knowledga, daath occurred et the time, dete end plece, end due to the ceuse(s) and menner as stated.

2 Description: To the best of my knowledga, daath occurred et the time, dete end plece, end due to the ceuse(s) and menner as stated.

2 Description: To the best of my knowledga, daath occurred et the time, dete end plece, end due to the ceuse(s) and menner as stated. 29a. Cartifler (Check only one) 29b. Signature and title, 29c, Licansa number 29d. Deta signed (Month, Day, Year) 30. Name and address of per son who complated causa of deeth (Item 23e) (Type, Print)

Registrar

MAR 1 1 1997

31. Dete filed (Month, Day, Year)

North St.

32. Registrar's Signature

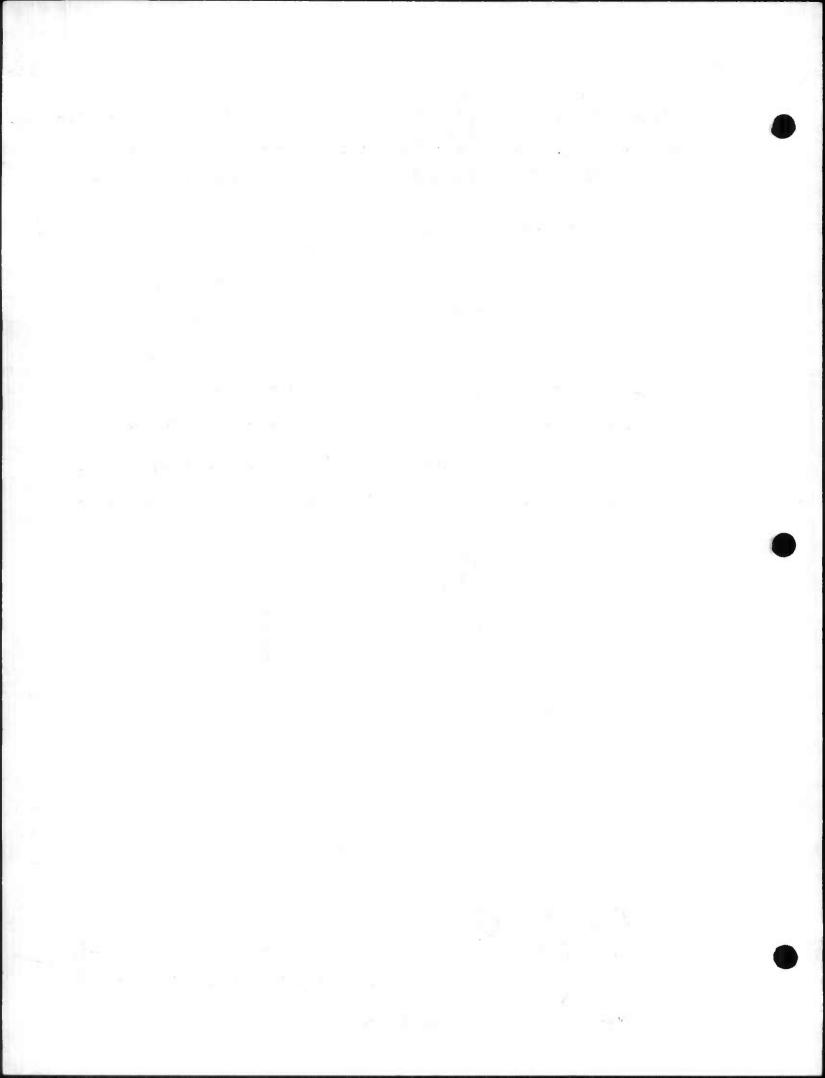
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Ar. John R. Mulve.

				State of Maryl		artment of rtificate of			eg. No.	7 08315	5
	Physic		1. Decedent's Nema (First, Middle, Las					2. Dete of Deet Month	th Day	3. Time of Death)
	/Medi Examir		Joseph P. Lam 4e. Fecility Name (If not institution, give	ocation of Daath	997 16;05 h	rs					
	Funeral Director		221 14 1122	7. Age (in	re Fac yrs. last birthdey)	ility If Under Yaar Months Deys		8. Dete of Birth (Month, Day, 1 - 27 - 2		9. Birthplace (State or Fora Country) Claymont, DE	ign
	in & m		Usual Residence of Decedent 10e. Stete 10b. County	10c	City, Town or Lo	cation				10d. Inside City Limi	its
	Many Med sh	tor	MD Ce	cil	Elkton					1 ☐ Yes 2 💢 🛚	No
	after death with the Manylar or flerns 23e or 28a-f show uniner must be notified at	Funeral Director	10a. Street and Number			10f. Zip Code	1001	1	0g. Citizan ot W		
	s 23 must	erai	1 Price Drive	12. Was Decedent Ever i	n II S 13 1		1921 Hispanic Origin? (S	necify Yes or No.		USA - Amarican Indien,	
020		by	1 Nevar Merried 2 Married 3 Widowed 4 Divorced	Armed Forcas? 1 ⊠ Yas 2 □ No If Yes, Give Yeer or Detes: 19		f Yes, specify Cut	Hispanic Origin? (S ben, Maxican, Puert Specify:	o Rican, etc.)	Biaci	White atc.	
Maryland 21215-0020	i within 72 hours lene. r than "natural", the Medical Ex	Completed	15. Decedent's Ed (Specify only highest grad Elementery/Secondery (0-12)	ucation de completed) College (1-4or 5+)	(Give	DO NOT use retire	a during most of wor ad)	king	16b. Kind of Bu	-	
12			12 17. Fathar's Name (First, Middle, Last)		Push	er Opera		ne (First, Middle, M	Steel I		
lan	should be filed of Mental Hyg marked other matic event, i	To Be	Charles A. Lamm	ey				s Brady	welden Sumeme	9)	
any		-	19e. Intormant's Neme/Reletionship (7	ype, Print)	19b. Meilir	ng Address (Stree	nt end Number or Au		, City or Town,	Steta, Zip Code)	
	s 1 and 2. f Health at flem 27 is other trau		John F. Lammey/Br				ourt, Wes	t Grove,	PA 19	390	
Baltimore,	8-2=8		20e. Method of Disposition 1 Burial 2 Cremation 3 4 Donetion 5 Other (Specify	Removel from State		sition (Neme of matory or other pla phs-on-t he		Dete 3		City or Town, State	
Balt	permit. Pa Departmen Important any Injury once.		21. Signeture of Funaral Service Lounn		Be	Nama and Addr Seson Me		rvices			
			23a. Part1. Entar tha disaasa, or comp shock, or heert teilure. List only o	ications that caused the cone couse on each line.						Approximete interval Batween	
	Physician /Medical Examiner		immediate Cause (Final disease or condition	Cerdon	Syasu	long	Useds	2		Onset and Deeth 3Uler	1
		-	resulting in death)	Due t	o (or es e consec						
	cate be asscuted physician and s the bunal-transit	Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Undertying Ceuse (Disease or injury	b. Due t	o (or es e conseq	uence of):				126	
68760,	ficate be axecut physician and is the bunal-tran	edicai	thet initiated events	C. Due to	o (or as e conseq	uence of):					
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Records,	requi	Completed						24e. Wes a perform		24b. Were autopsy finding aveilable prior to completion of cause of deeth?	S
I Re	The late he	Com						1 □ Yε	s 2000	1 □ Yes 2 No	
Vital	Physician: The this certificate ral director, pag	Be	25. Wes case reterred to medical examiner?	Hospitel:				oth (Check only on	Θ)		
of	Phys ral di	. To	1 Yes 2 No	1 ☐ Inpatient :	2 ER/Outpetlen	I 3LI DOA		oma 5 Reside			
on	Attending Ph ir death. ector: After th by the funeral	ation	1 Netural 5 Pending 2 Accident investigation	(Month, Dey Year	r) Injury	Wo	ork?]Yes 2 □ No		winding occurre		
Division	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Piece of Injury - A building, etc. (Sp.	At home, ferm, streecify)	eet, tectory, office		28f. Location (St City or Town	reet end Numbe n, Stete)	er or Rural Routa Number,	
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled In	edical (29e. Certifier (Check only one)	sician: To the best of my ner: On the basis of examend megalensteted.	knowledge, deeth inetion end/or Inv	occurred et tha t restigetion, in my	ime, dete end piece opinion, death occu	, and due to the ca rred et the time, da	ause(s) and mer ate and piece, e	nner as stated. nd due to the cause(s)	
	Withir To the Comp	M	29b. Signature and little of certifier	1. X		29c. Lican	sa number	2	9d. Dete signed	(Month, Dey, Year)	
	/ 11/0		Market			N58	339	m	arch	10, RG7	/
	6+141		30. Neme and eddress of parson who c	LICH 101	Eur	Print)	ruel Be	lan.	MD-	LIOIS	
	Sta Registr		31. Dete tiled (Month, Dey, Year)	32. Registrer's Si		1.00	·				

DHMH 16 Rev 6/95



State Registrar

Funeral

Director

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Physician /Medical

Examiner

physician a

signed by the et d be detached for

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After

Director: /

To the Hospital o within 24 hours eff To the Funeral DI completely filled in

The lew requires that the death certificate be executed

Records, P.O. Box 68760,

Division of Vital

the Hospital or Attending Physician: nin 24 hours efter death.

traumatic event, the Medical Examiner must be notified at

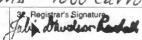
the Maryland

filed within 72 hours efter death

Maryland 21215-0020

Baltimore,

31. Date filed (Month, Dey, Year) MAR 03 199



35 R	BALTIMORE, MARYLAND 21215-0020	vurs after death. Page 6 may be retained by the hospital or attending physicia
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1		-
	DIVISION OF VITAL RECORDS, P.O. BOX 68760,	L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within rours after death. Page 6 may be retained by the hospital or attending physicial

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within wours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, he filed within 72 hours after death with the State Dept. of Health and Mental Horlene prior to burial cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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Pages 1, 2, 3 should

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

BEG NO.

	REGISTRAR	CERTIFIC	ATE OF DEATH	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) ULYSSES	LONG		2. DATE OF DEATH MONTH DA	Y YEAR	3. TIME OF DEATN	
	0113313	LONG			1997	1:15 AM M	
	4. SOCIAL SECURITY NUMBER 5. SEX 6.		FUNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTN (Month, Day, Year)	8. BIRTHI Country	PLACE (State or Foreign	
	240-12-5109 1 [™] 2 □ F	75 YRS.	ONTHS DAYS HOURS MIN.	Sept. 29,1		nche, N.C.	
	9e. FACILITY NAME (If not institution, give street and number)	9	b. CITY, TOWN OR LOCATION OF DE	ATN	9c. COUNTY OF DE		
DIRECTOR	12415 Lytton Ave.		Brandywine		Prince	Georges	
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY					-0	
<u> </u>			OWN OR LOCATION			10d. INSIDE CITY LIMITS?	
	Md. Prince Georges	Bra	ndywine			1 X YES 2 NO	
¥			10f. ZIP CODE		10g. CITIZEN OF W		
FUNERAL	12415 Lytton Ave.		20613		U.S.A	•	
2	11. MARITAL STATUS 1 Never Merried 2 Merried 12. WAS DECEDENT E FORCES? 1 X		13. WAS DECENDENT OF HISPAN It yes, specify Cuben, Mexica	NC ORIGIN? (Specify Yes in, Puerto Ricen, etc.)	or No — 14, RACE Black,	- American Indien, White, etc.	
E	3 Wildowed 4 Divorced IF YES, GIVE WAR	OR DATES	1 YES X NO Specifi	y:	Specifi	Black	
	15. DECEDENT'S EDUCATION	16a. DECEDENT'S US	IIAL OCCUPATION	THE VIEW OF BUILD	SINESS/INDUSTRY	DIACK	
	(Specify only highest grade completed)	(Give kind of world life. Do NOT use n	done during most of working	IOD. KIND OF BUS	SINESS/INDUSTRY		
2	Elementary/Secondary (0-12) College (1-4 or 5+)	Texti	le Worker	Mill			
COMPL	17. FATNER'S NAME (First, Middle, Last)		18. MOTNER'S NA	ME (First, Middle, Meiden	Sumame)		
	Addie Long			ie Lipscomb			
BE	19e. INFORMANT'S NAME (Type/Print)	19b. MAILING AD	DRESS (Street and Number or Rural I				
일	Irvin Long/ Son	11.00	Lytton Ave.,Bra				
Í	20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF I	DISPOSITION / Name of		CATION — City or Tox	rn. State	
1	1X Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	camatery, crematory or other Church Cer	metery 3/		vell Cty.		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	0.00201.00	22. NAME AND ADDRESS OF FA	CILITY			
	111 Q. O. 11.				uneral Home		
-	22 BARY I STORY IN THE	4	389 Rhode Isl	Land Av., NV	Washing,		
- 1	23. PART I. Enter the diseases, or complications that coshock, or heart failure. List only one cause	on each line.	enter the mode of dying, auc	h sa cardiac or reapi	ratory arrest,	Approximate Interval Between	
	iMMEDIATE CAUSE (Fine)		. 0			Onset and Death	
	reaulting in death)	AS A CONSEQUENCE OF	ailure			4 years	
	DOE TO (OF	AS A CONSEQUENCE OF					
5	Sequentielly list conditions, b.	AS A CONSEQUENCE OF):					
₹	cause. Enter UNDERLYING					İ	
CERTIFICATION	CAUSE (Disease or injury that initiated events DUE TO (OF	AS A CONSEQUENCE OF):					
	resulting in death) LAST						
DICAL	PART II. Other algnificant conditions contributing to de	eth but not resulting in	the underlying cause given in	Part i. 24a. WAS AN PERFOR		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
				1 YES 2		COMPLETION OF CAUSE OF DEATH?	
N N				_ _		1 YES 2 NO	
ž	DID TOBACCO USE CONTRIBUTE	TO CAUSE OF	DEATH YES NO				
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:		26. PLACE OF DEATH (Ch	eck only one)			
2	1 YES 2 NO 1 Inpatiant 2 E		☐ Nursing Nome 5 Residence	6 Other (Specify)			
	27. MANNER OF DEATH 28s. DATE OF INJ (Month, Day,	URY 28b. TIME (fear) INJUR	Y WORK?	28d. DESCRIBE NOW II	NJURY OCCURED		
	2 Accident Investigation		M 1 YES 2 NO				
3	3 Suicide 6 Could not be detarmined 28e. PLACE OF It building, etc.	IJURY — Al home, term, stra- (Specify)	et, tactory, offica	28f. LOCATION (Street a City or Town, State)	and Number or Rural Ro	oute Number,	
- 1							
MPCE		knowledge, death occurred a					
	29e. CERTIFIER (Check only						
Š	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my		n my opinion, death occured at the	time, date end place, an	d due to the cause(s)	and manner ee stated.	
	(Check only CERTIFTING PATSICIAN: To the best of my		29c. LICENSE NUM	MBER	29d. DATE SIGNED		
	(Check only one) 2 MEDICAL EXAMINER: On the basis of axam			MBER		Month, Day, Year)	
NO.	(Check only one) 2 MEDICAL EXAMINER: On the basis of axam Wh. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE	ination end/or investigation, i	29c. LICENSE NUM	MBER 3	29d. DATE SIGNED	Month, Day, Year)	
NO SHE	(Check only one) 2 MEDICAL EXAMINER: On the basis of axam Wh. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE	ination end/or investigation, i	29c. LICENSE NUM	MBER	29d. DATE SIGNED	Month, Day, Year)	
NO SERVICE	(Check only One) 2 MEDICAL EXAMINER: On the basis of axam 196. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE MARTIN D. WETTZ 7525 31. DATE FILED (Month, Day, Year) 32. PEGISTRAR'S	instion end/or investigation, instinction end/or investigation, instinction of the second control of the secon	29c. LICENSE NUM	MBER 3	29d. DATE SIGNED	Month, Day, Year)	

State of Maryland / Department of Health and Mental Hygiene 08318 Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Deeth Dey 1997 **Physician** Month March 2, Virginia Ann 5:45 am /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** 5603 Rittenhouse Street Riverdale Prince George's If Under 1 Yeer If Under 24 Hrs.

Months Deys Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplece (Stete or Foreign Country) **Funeral** 1□M 2ĬXF Yrs Director 215-32-8837 60 25, 1936 May Washington, DC Usuel Residence of Decedent 10e Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 10d. Inside City Limits Director 1 ♥ Yes 2 No Prince George's Riverdale 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 5603 Rittenhouse Street 20737 U.S.A. Funerai 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 1 □ Never Merried 2 N Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mantal Hyglane. Important: If Item 27 Is marked other than "n any Injury or other traumatic event, tra Mod once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Cook Parkdale High School 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Marshall Pilkerton Christine Virginia Baldwin 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Ralph Lamot - Husband 5603 Rittenhouse Street, Riverdale, Maryland 20737 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Date 1 X Buriei 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Fort Lincoln Cemetery 03/06/97 Brentwood, Maryland 21/ Signature of Funcial Service Licensee 22. Neme end Address of Fecility Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, Maryland Pert 1. Enter the dise ise, or complications that caused the dise is. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each life. Approximete intervei Between Onset end Death Physician /Medical immediate Cause (Final diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting in deeth) Lest and Due to (or es e consequence of): ettending physician for use es the buria Physician/Medical Due to (or es e consequence of): ed by the e Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings evellable prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? peeu pege 2 certificate 1 🗆 Yes 2 No 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice fiely filled in by the funeral director; p Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 A Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menper of Death 28a. Dete of injury (Month, Dey Year) 28b Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation 1. Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft to the Funeral Dir domoletely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examinar: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner steted. 29a, Certifier Medical 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) P2030Z 30. Name end eddress of person who completed cause of data (Item 23e) (Type, Print) 4410 74th Avenue, Landover Hills, Maryland 20784-2222 Robert J. Gereige, M.D. 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State Jalia Stavilson Rendell Registrar

DHMH 16 Rev 6/95

the Maryland

death

72 hours eftar

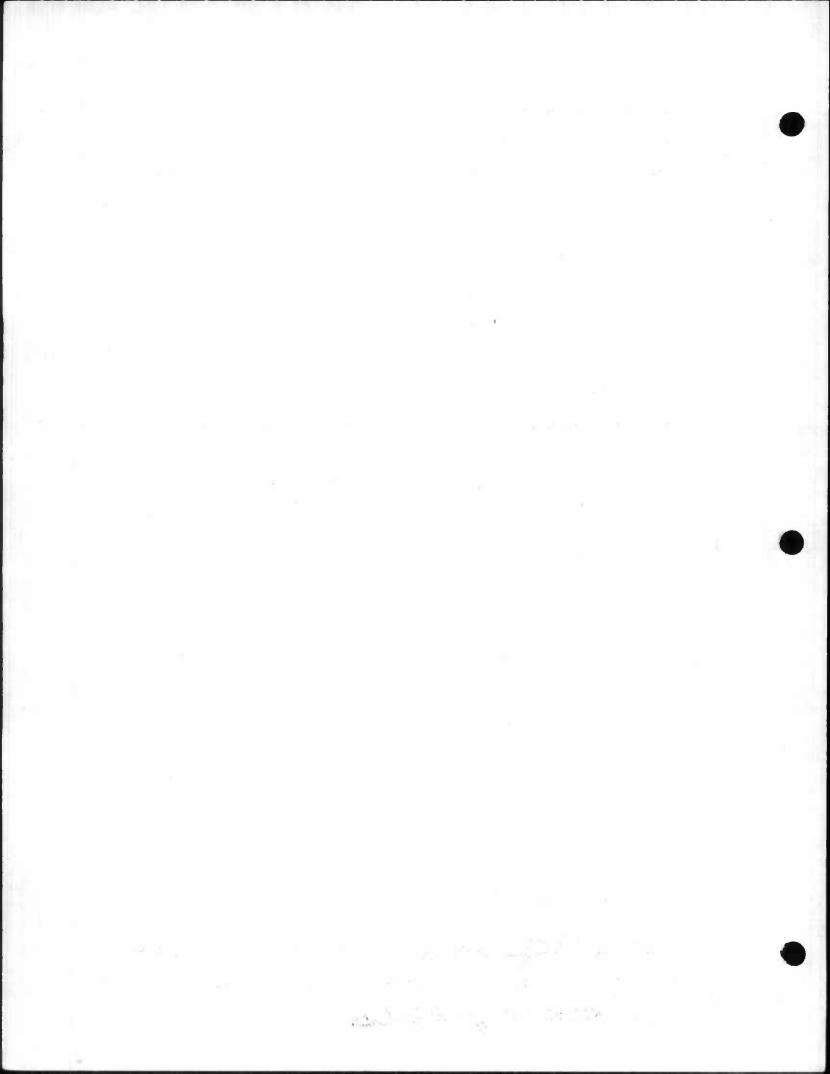
Baltimore, Maryland 21215-0020

The lew requires that the death certificeta be axecuted

P.O. Box 68760,

Records,

Division of Vital

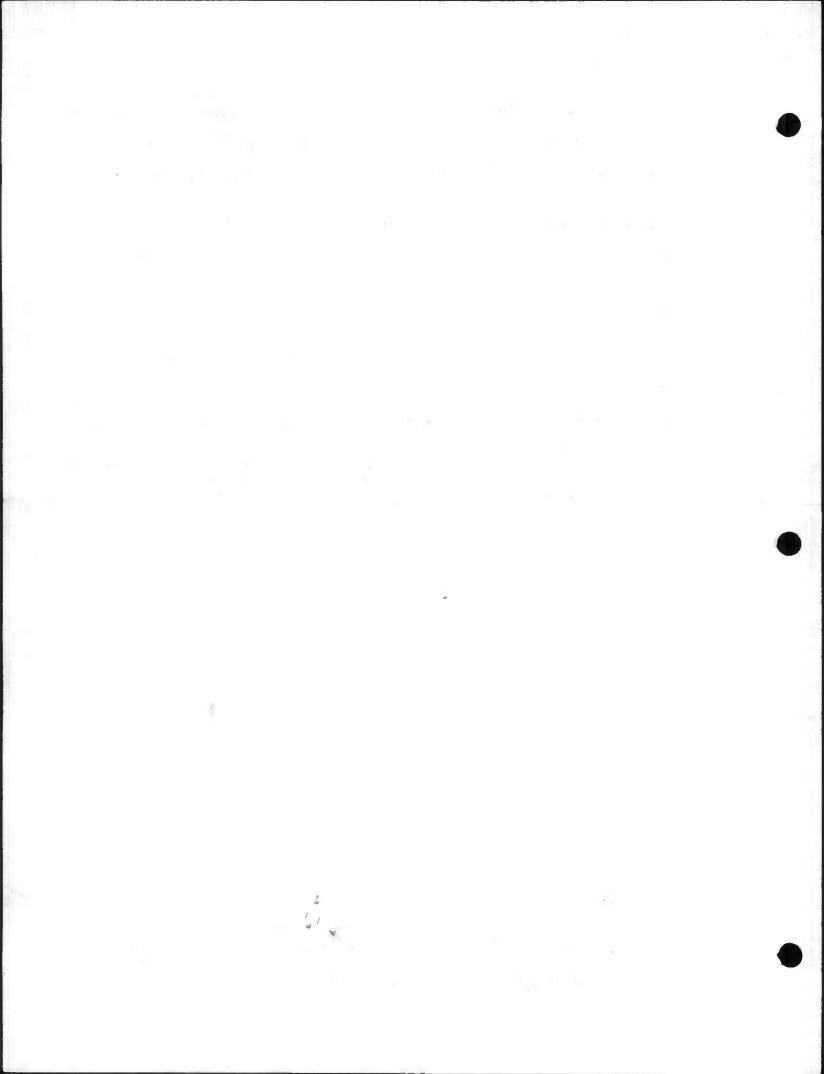


State of Maryland / Department of Health and Mental Hygiene 0.7

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/Medical Examiner		te. Fecility Neme (If not institution,		er)		~~	4b. City, Town, or L	A STATE OF THE STA		y of Deeth	12:10A
LAUITIIIICI	ı	Washington	Adventis	st			Takoma			C.	
uneral	5	5. Social Security Number	6. Sex 7.	Age (In yrs.	lest birthdey	if Under 1 Yes	r if Under 24 Hrs.	8. Dete of Bir (Month, De			lece (Stete or For
rector	1	230-34-8784 Usuel Residence of Decedent	1□M 2□ F	69	Yrs.	Months Dey	s Hours Min.	Sept	.16,27	Sug	argrove
≹ 11		10e. State 10b. County		10c. Cit	ty, Town or L	ocation				1	0d. inside City Lir
the notified at Director				Tol	lachir	ngton,	D C				1⊠Yes 2□
Tec not	1	10e. Street end Number			I DITT	10f. Zip Code			10g. Citizen ot	Whet Coun	itry?
r tems 23s or 25s-f s niner must be notified Funeral Director		668 Jefferson	n St., N.	Ε.		207	8.2	4	UNITE		tates
ther mu	1	11. Maritei Stetus	12. Wes Deceder Armed Force		,S. 13.	Was Decedent of	Hispenic Origin? (Sp ben, Mexican, Puerto	pecify Yes or No		ce - Americ	an Indien,
Examiner must Examiner must by Funeral		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 🖾 🏎 2 [if Yes, Give Yeer or Detes] No		1 Yes 2 No		Rican, etc.)	Specific Spe	ock, White, of	etc.
ted lead		15. Decedent's	Education		16a. Dece	edent's Usuel Occ	upetion		16b. Kind of B	Business/Inc	lack
t, the Medical Completed		(Specify only highest Elementary/Secondery (0-12)	grede completed) College (1-4o	r 5+)	(Give	e kind of work don DO NOT use retii	upetion e during most of work ed)	king			
E E		12	2	. 57)	X-F	Ray Te	chnician		Hosp	ital	
d othe event, Be C		17. Fether's Neme (First, Middle, La	ast)				18. Mother's Nam	e (First, Middle			
arked artic en		Fred J. Lee					Cleo	Cox			
		19e. Intorment's Name/Reletionship	p (Type, Print)		19b. Meii	ing Address (Stree	et and Number or Rui	ral Route Numb	er, City or Town	, Stete, Zip	Code)
other traun		Barbara Lee	/ Wife		66	8 Jeff	erson St	. NF	Wash	. D	C. 2075
	2	20e. Method ot Disposition		20b. P	lece of Disp	osition (Neme of emetory or other pi	lace)	Date	20c. Location	- City or To	wn, Stete
1 o		1 Buriel 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spe		0		Lco Ceme		-7-97	QUANT	ICO.	Va.
mportant: ny injury nice.	2	21. Signeture of Funerel Service Lic	censee			2. Name end Add	roop of English		Funera		
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sician	1	23e. PertY. Enter the diseese, or co shock, or heert tellure. List or	omplications that caus nly one cause on each	ed the deetl line.	h. Do not en	nter the mode ot dy		or respiretory e	rrest,		Approximete intervei Between Onset end Deetl
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State of Maryland / Department of Health and Mental Hygiene

						Certific	cate of	Death	•	Reg. No.	9/	08320
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	Physic /Medi		Lucy E.	McKenn	a				Februa	ry 27, 1	Yeer 997	9:45 AM
)	Examir		4e. Fecility Neme (If not Institution, g	ive street end number)				4b. City, Town, or				7,72 111
			2101 Fairland R	oad				Silver	Spring	Mont	gomer	·V
	Funeral		Sociel Security Number 6.		e (In yrs. iest b		Inder 1 Year	If Under 24 Hrs	S. 8. Date of Bir			ace (Stete or Foreign ry)
П	Director		579-16-4746	1□M 2図F	98	Yrs.	nths Deys	Hours Min	Oct. 2	9, 1898	West	Virginia
	9		Usuel Residence of Decedent									
	the sylar	_	10e. Stete 10b. County		10c. City, Tov	wn or Location	1				10	d. Inside City Limite
	2 7 H	Director	Maryland Montgom	ery	Silv	er Spr	ing					1 ☐ Yes 2√€ No
	5 P	ire.	10e. Street end Number				f. Zip Code			10g. Citizen of \	Whet Countr	ry?
	death with the Maryland ms 23e or 28e-f show crount be notified at	<u>a</u>	2101 Fairland R	oad			2090)4		US	A	
	9 89	Funeral	11. Meritel Status	12. Wes Decedent Armed Forces?	Ever in U,S.	13. Wes D	ecedent of	Hispanic Origin? (S ben, Mexican, Puer	Spacify Yes or No		e - America	
0	be filed within 72 hours after death with the Marylar tal thyglene. I other than "natural", or items 23e or 28e-f show ovent, the Medical Examiner must be notified as		1 ☐ Never Merried 2 ☐ Merried	1 Yes 2 1	No				no rican, etc.)		ck, White, et	IC.
21215-0020	ours Frail,	l by	3 ☑ Widowed 4 ☐ Divorced	Yeer or Detes:		1010	es 2½ No	Specify:		Specify	· Wh	hite
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уlа		2	Ami Simmons					Mary E	tta Loug	gh		
Maryland	2568		19e. Informent's Neme/Reletionship		19	b: Melling Add	dress (Stree	t and Number or R	lural Route Numb	er, City or Town,	Stete, Zip (Code)
	and palify a 27		Kitty Knill / G	ceat-niece	6	Jill (Court,	Reister	stown, N	[aryland	2113	36
ore	C S S S S S S S S S S S S S S S S S S S		20e. Method of Disposition № Buriel 2 Cremetion 3	Demoval from State	20b. Plece o	of Disposition ery, cremetory	(Neme of or other ple	ece)	Dete	20c. Locetion -	City or Tow	n, Stete
Ĕ	Pages nant of i		4 Donetion 5 Other (Spec		Cedar	Hill (Cemete	rv	3/10/97	Suitland	l. Mar	vland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If tem 27 is any injury or other tra 2008.		21. Signeture of Funerel Service Lice	enseg	1/20	//22. Nam	and Addr	ess of Fecility H	ines-Rin	aldi Fur	ieral	Home
œ	SSEES		Man ~	Don't	HAU	Der	00 Ne	w Hampsh	ire Aven			
			3a. Pert1. Enter the disease, or conshock, or heert feilure. List only	nplications that caused	the deeth. Do	not enter the	mode of dv	pring, Ma	arytand ic or respiretory e	20904 rrest.	1 1	Approximete
	Physician		shock, or heert feilure. List onl	one ceuse on eech lir	10.		,		,			Intervel Between Onset and Deeth
a	/Medical		Immediate Cause (Final		Was			Reute	2			Level
П	Examiner		disease or condition resulting in deeth)	θ.	Due to (or es e			ecule				1.com
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m	deat e ett d for	Physician/	Pert II. Other significent conditions	contributing to deeth bu	it not resulting	in the underly	Ing cause g	ven in Pert I	23h Did	tohacco use co	ntribute to (the cause of death?
P. 0.	t the d	hys					g outle g			Yes 2 No		ably 4 ☐ Unknown
S,	es that igned l	ру Р			<u> </u>					27.10	00	,
ď	law requires that the death as been signed by the etter 2 should be detached for									en eutopsy		e eutopsy findings
Record	v require been si should t	Completed							perfo	med?	com	leble prior to apletion of ceuse eeth?
Re	The law ate has page 2	E								400		
O	vician: The certificate irector, pag		OF Management to market							Yes 2□No	10	Yes 2□ No
Vita		Be	25. Wes cese referred to medicel exeminer?	Hospitel:			Ot Ot	hor: . e	eth (Check only			
of	Phys ral d	5	1 ☐ Yes 2 No 27. Menner of Deeth	1 ☐ Inpatie		utpetient 3L Time of	I DOA	4 Nursing	Home 5 ☐ Resi	dence 6 ∐Oth how injury occur		
on	tending Ph leath. or: After th the funeral	Tion I	1 Neturet 5 ☐ Pending	(Month, De)		Injury	28c. Inju Wo	ork?]Yes 2 □ No	200. 00001100	now injury coodin		
S	or Attending Physician: after death. Director: After this certific i in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not	De Diago of Init	inv - At home for				28f Location /	Street end Numb	er or Rurel	Route Number
Division of		er.	4 ☐ Homicide determined	building, etc	(Specify)	aiii, 311001, 10	otory, office		City or To		0, 0, 1,0,0,	, route realition,
	Hospital 24 hours Funeral itely filled		29a. Certifier 1 Certifying P	nysician: To the best of	f my knowledo	e death occur	rrad at the ti	imed date and place	e and due to the	cauca(s) and me	nnor os sto	ated
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edicai	(Check only 2 Medical Exa	miner: On the basis of end menner sta	examinetion er	nd/or Investige	etlon, in my	ophion, deeth occ	urred et the time,	date end plece,	end due to t	the ceuse(s)
	To the within 2 To the comple	Me	29b. Signeture end title of certifier	01101111011101	100.		29c. Licen	se number.		29d. Date signe	d (Month, D	ev. Year)
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7	2	-	- practice	mas M	V /					2/1	1//	
)		30. Nemg and eddress of person who	completed ceuse of de	eeth (Item 23e)	(Type, Print)	ENNU	LANE	LAURE	4 110	2.	20.7
			31 Data filed (Month Day Vaca)	1011/1011	. , 83	7 - 617	3,-,-,7		//-	1 100.	00	10/
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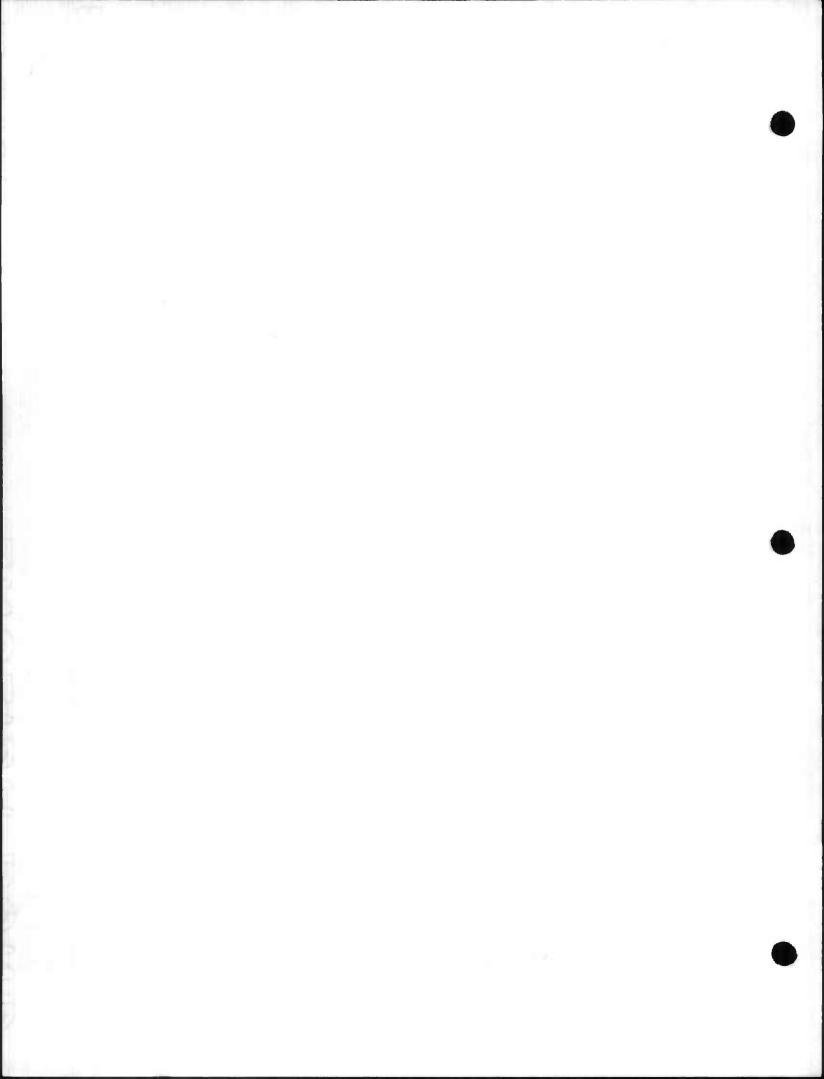


DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	IHE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burdal, cremation, or removal.	ORTANT: I item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
) THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certifical	D THE FUNERAL DIRECTOR; After this certificate has been signed by the attending phy	e filed within 72 hours after death with the State Dept. of Health and Mental Hygiene I	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other

	1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF H		MENTAL	HYGIENE REG. NO.				
The second second	1. DECEDENT'S NAME (First, Middle, Last)	Carmen Ber	ry Mo	ses		2. DATE O MONTH O 2	DE DEATH DAY		EAR	: 05 A M	
	4. SOCIAL SECURITY NUMBER 578-07-8341	5. SEX 6. AGE (1)	In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		Day, Year)		Country)	CE (State or Foreign	
TOR	99. FACILITY NAME (If not institution, give V111a Rosa Nurs: RESIDENCE OF DECEDENT			Mitchell	DR LOCATION OF DE	EATH	OF DEATH	orge's			
FUNERAL DIRECTOR	10a. STATE 10b. COUNT	ce George's	12.2	ry, town or locate					10d. INSIDE CITY LIMITS? 1 VES 2 XX		
ERAL	100. STREET AND NUMBER 3800 Lottsford Re	oad			ZIP CODE			U.S.A.		COUNTRY?	
B⊀	11. MARITAL STATUS 1 Never Merried 2 Merried 3 A Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 TYES IF YES, GIVE WAR OR DA	2 1 NO	If yes, sp	ENDENT OF HISPAI ecity Cuban, Mexico 2 NO Specif	in, Puerto Ri		or No 14.	Black, W	American Indian, hite, etc. Vhite	
COMPLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	UCATION de completed) College (1-4 or 5 +)					KIND OF BUS	INESS/INDUS	PRY		
E COM	17. FATHER'S NAME (First, Middle, Lest) Somerset Dyso	on Berry			16. MOTHER'S NA			Surname)			
TO BE	19e. INFORMANT'S NAME (Type/Print) Alexander MacKay	-Smith		Box 19					de)		
	20e. METHOD OF DISPOSITION 1 Description S Cremation S Res 4 Donellon S Other (Specify)	moval from State of a		re of Disposition by or other place)	(Name	3/7	Was	hingt	on, l	DC	
1000	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOSEph Gawler's Sons, Inc. 5130 Ave., N.W. Washington, D.C. 20										
	23. PART I. Enter the disease, or ahock, or heert fellure IMMEDIATE CAUSE (Finel disease or condition resulting in death)	e. List only ne cause on e	ach line.		de of dying, suc	ch as cerd	lac Dr reapir	atory arrest	,	Approximate interval Between Onset and Death	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b	CONSEQUENCE								
ERTIFI	CAUSE (Disease or Injury that Initiated events resulting in death) LAST										
PHYSICIAN: MEDICAL C	PART II. Other algorificent condition	one contributing to death b	ut not resulting	in the underlyin	g cause given in	Part I.	24e. WAS AN PERFORM	MED?	CO OF	PERE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO	
AN	25. WAS CASE REFERRED TO MEDICAL			26. P	LACE OF DEATH (C	heck only one	9)				
SIC	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Outs	patient 3 DOA	Nursing Hor	ne 5 🗆 Residence	6 ☐ Other	(Specify)			-X-1 T.51	
	27. MANNER OF DEATH 27. MANNER OF DEATH 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TI	ME OF 28c. IN.	JURY AT DRK? YES 2 NO	_	CRIBE HOW IN	JURY OCCUP	RED	777 01	
TED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e, PLACE OF INJURY	/ — At home, farm.	, streel, factory, offic	00	28f. LOCA City o	ATION (Street e or Town, State)	nd Number or	Rural Rout	e Number,	
COMPLETE	(Orack Oray -	SICIAN: To the best of my know								nd manner as stated.	
BE CC	296. LICENSE NUMBER 29d. DATE SIGNED (I								IGNEO (M	onth, Day, Year)	
10	36. NAME AND ADDRESS OF PERSON A	THO COMPLETEO CAUSE OF DE	ATH (ITEM 27) (7)	Print)	in A	2	CAL	Van A	wi	2.5706	
	31. DATE FILED (Month, Day, Year) MAR 0 F	32. REGISTRAR'S SIGN	Davidon		-, /	1	WIF.				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Deta of Death Month Yaar ROBERT W. MEINZER 1997 MARCH 1020 03 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth ROCKVILLE MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL If Under 1 Yeer | If Under 24 Hrs. 5. Social Sacurity Number 6 Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthpieca (Stata or Foreign Country) 1⊠M 2□F Deys Yrs. 578-40-1245 65 October 1,1931 Washington, D.C. Usuai Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1⊠Yas 2□No Maryland Montgomery Rockville 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 1902 Stanley Avenue 20851 United States 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Biack, White, etc. 1 ⊠Yas 2 □ No If Yas, Giva Yaar or Datas: 1951-1959 1 ☐ Nevar Married 257 Married 1 ☐ Yas 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education 16b. Kind of Businass/Industry (Specify only highast grada complated) Elamantary/Secondary (0-12) College (1-4or 5+) 10 Sheet Metal Mechanic Construction 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maidan Sumama)

Mary Carter

22. Name and Addrass of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

20c. Location - City or Town, Stete

Rockville, Maryland

Approximate Interval Batwaan Onsat and Daath

MONTHS

YEARS

19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Steta, Zip Code)

Park

1902 Stanley Avenue Rockville, Maryland 20851

Physician /Medical Examiner

Physician

/Medical

Examiner

10a Stata

Funeral

Director

Nems 23s or 28s-f show

offied within 72 hours after of Hygiens.

i 2 should be fill h and Mental H is marked off

Pages 1 and 2 s ment of Health an permit. Pages 1 and 2: Department of Health as Important: If face 27 is any lojury or other tracents.

Baltimore, Maryland 21215-0020

2

the Medical Examiner must be notified at

Director

Funeral

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Completed

Be 2

The lew requires that the death certificete be executed pue Box 68760 ettending physician Division of Vital Records, P.O. certificate i or Attending Physician: effer death.
Director: After this certifica within 24 hours e To the Funeral D

8+

State

Registrar

Examiner Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Ceusa (Disaasa or Injury Physician/Medical thet initiated avants rasulting in deeth) Last Dua to (or as a consaguanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings evallabia prior to Completed 24a. Was en eutopsy performad? completion of cause 1 ☐ Yas 2 ☑ No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to madical Be 26. Placa of Daath (Check only ona) axaminar' Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 1 Tes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturei 5 Panding 1 ☐ Yas 2 ☐ No investigation 2 Accident 6 Could not be datarmined 3 Suicida Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Placa of Injury - At home, ferm, streat, factory, office building, etc. (Specify) 4 Homicide Medicai 29a. Cartifian 1 🗹 Certifying Physician: To tha best of my knowladga, daath occurred at tha tima, data and place, end dua to the causa(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigetion, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. Licensa number 29d. Date signed (Month, Dey, Year) 29b. Signatura and title of certified

20b. Pleca of Disposition (Name of comatay, crematory or other place)
March 6, 1997
Parklawn Memorial

METASTATIC GASTRIC CANCER

CANCER

M00335 Rockville, Maryland 20850-28

23a. Parti. Enter the disaasa or complications that causad tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. M00335

6 of death (Item 23a) (Type, Print)

9707

MD

Dua to (or as a consequence of):

ASTRIC

MEDICAL CENTER OR ROCKVILLE MD 20850 32. Registrar's Signature 31. Data filed (Month, Dey, Year) who Devidson MAR 0 6

ERTY

HA66

30. Nema and eddrass of person who completed co

Robert W. Meinzer, Sr.

19a. tnforment's Name/Ralationship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signatura of Funaral Service Licansei

20a. Mathod of Disposition

Immediete Causa (Final

disaasa or condition rasulting in daath)

Rosemary Meinzer/ Wife

1 ☑ Burial 2 ☐ Cremetion 3 ☐ Ramoval from Stata

DHMH 16 Rev 6/95

94

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadant's Nama (First, Middla, Last) 2. Data of Daath Daniel Bruno Mistrik March 3, 1997 7:47 PM 4a. Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Daath 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Undar 24 Hrs. 8. Data of Birth (Month, Day, Yaar) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foraign Country) Days 1₺ M 2□ F Feb. 4, 1928 086-20-6426 New York Usual Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 M No Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 4513 Gladwyne Drive 20814 United States 12. Was Decedant Evar in U,S. Armad Forcas? 12 Yas 2 No If Yas, Giva 1945 — Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 Navar Married 2 Marriad 1 ☐ Yas 2X No Specify: Specify: 3 Widowad 4 Divorced White 1949 16e. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4 or 5+) Teacher Art 17. Fethar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meidan Sumama) William Mistrik Martha Elisabeth Kalina 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Coda) Marion G. Mistrik/Wife 4513 Gladwyne Drive, Bethesda, Maryland 20814 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of Placa of Disposition (Nama or cematary, cramatory or other place) March 7, Data 20c. Location - City or Town, Stata 1 € Burial 2 Cramation 3 Ramoval from Stata 1997 4 ☐ Donation 5 ☐ Othar (Specify) Maryland Veterans Cemetery Crownsville, Maryland atum of Funeral Service License 22. Nama and Addrass of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue asa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, e. List only one cause on each line. Intarval Batween Onsat and Death Immediata Causa (Final Myocardial Interation, Cardiogenical should diseasa or condition rasulting in daath) Dua to (or as a consequence of): Coronary Artery
Dua to (or as a consequenca of): Discase Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Diseasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consaquanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Wara autopsy findings availabla prior to completion of causa of daath? 24a. Was an autopsy performed? 1 ☐ Yaa 2 ☐ No 25. Was casa refarred to medical examplear? 26. Place of Deeth (Check only ona) examinar? 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify)

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Physician

/Medicai

Examiner

Funeral

Director

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Physician /Medical

altimore, Maryjand 21215-0020

P.O. Box 68760 Records, Division of Vitai Hospital or Attending Physicien: 24 hours efter death.
Funeral Director: After this certificately filled in by the funeral director, I • Funerel To the Hosp within 24 hou To the Funer completely fi

27. Mannar of Death

1 Natural

2 Accidant 3 Suicida

4 Homicida

29a. Cartifiar

5 Pending Invastigation

6 Could not be

5+1

State Registrar

Medical

29b. Signature and life of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) M.D. D41762 and address of person who complated causa of death (Item 23e) (Type, Print)

28b. Tima of

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

loha Golden 10810 Connecticut Ave., Kensington, MD 20895

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) end manner as stated.

22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

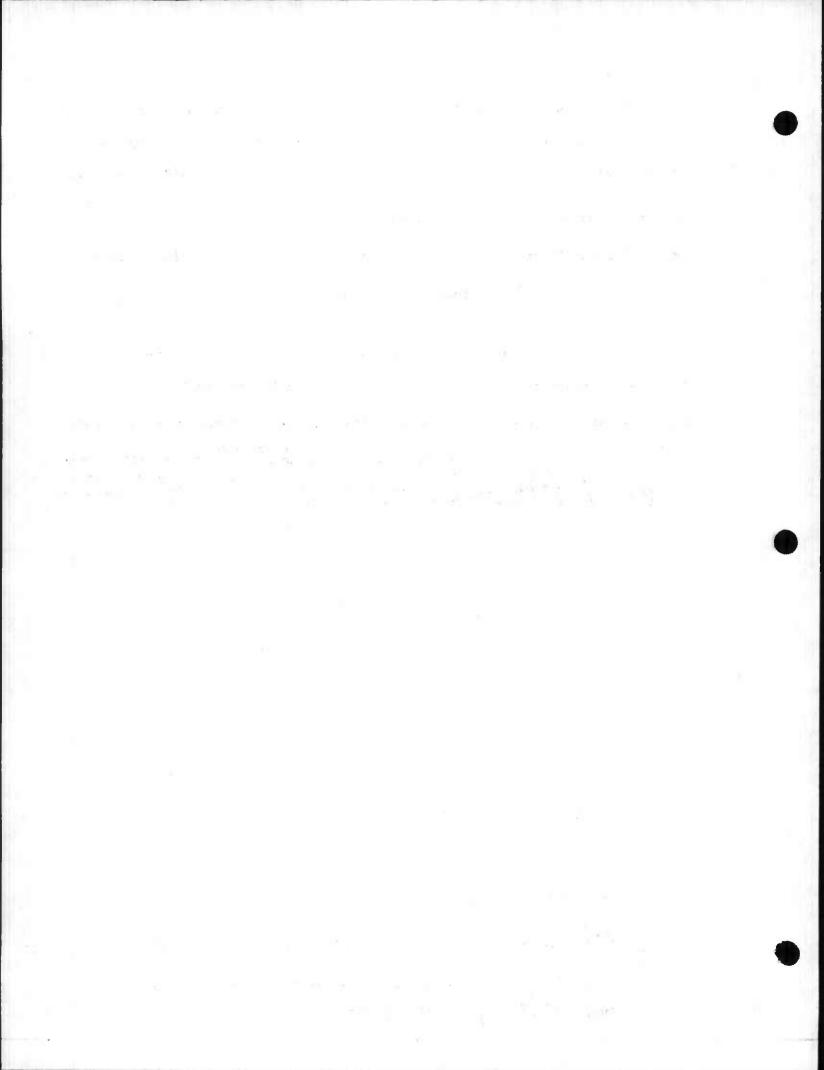
28d. Dascribe how Injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

March 4, 1997

32. Ragister's Signature 31. Data filed (Month, Day, Year) MAR 0 6

28a. Deta of Injury (Month, Dey Year)



State of Maryland / Department of Health and Mental Hygiene

08324 Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death February 28, 1997 **Physician** 11:16AM August T. MERKEL /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lanham Prince Georges Doctors Community Hospital 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey Year) 9. Birthplace (Ste Country) August 8, 1909 Maryland 5 Social Security Number 9. Birthplace (State or Foreign **Funeral** 1XXM 2 F 578-03-1878 Director Usuei Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Bowie XXYes 2 No Director 288-71 8 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? b munt be Items 23a 9401 Laurel Bowie Road 20720 United States Funeral 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specity Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Race - Amaricen Indian, Bieck, White, etc. Med within 72 hours after of Hygiene. Ther than "natural", or list 1 ☐ Yes XX No If Yes, Give 1 Never Married 2 Married *Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yes 2 XX Specify: þ 3XXWidowed 4 □ Divorced *natural*, Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) The Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry International Union Elementery/Secondary (0-12) Coilege (1-4or 5+) Painter/Interior Decorator of Painters marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental Ernt Merke1 Freda Schuman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Important: If Item 27 is any injury or other trau John Merkel (son) 9411 Laurel Bowie Road Bowie, Maryland 20b Piece of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, Stete XXBuriel 2 Cremetion 3 Removei from Stete First Lutheran Church of 3/3/1997 4 ☐ Donetion 5 ☐ Other (Specify) Bowie, Maryland Bowie Cemetery 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Md. 20705 23a. Peri1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart failure. List only one ceuse on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) **Examiner** Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Lest and P.O. Box 68760, Physician/Medical the Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? signed by 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings eveileble prior to Completed 24a. Wes en autopsy completion of cause of death? page 2 1 Yes & No 1 Yes certificate Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifice Be 25. Wes cesa raferred to seeicei exeminar? 28. Piaca of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Neturel 5 Pending 1 Yes Investigation 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of Injury - At home, ferm, straet, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours e To the Funeral D completely filled pelli Cartifying Physician: To the best of my knowladga, death occurred et the time, dete end piece, end dua to tha causa(s) and mennar as stated.

Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et tha tima, data and piace, end due to the cause(s) end mannar statad. 29e. Cartifier Medical the 29b. Signeture end title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed ceuse of deeth (frem 23e) (Type, Print) 3231 Superior Lane, Suite A-6, Bowie, MD 20715 David Siegel, MD 32. Registrar's Signeture 31. Date filed (Month, Dey, Year) State ina Davidson

DHMH 16 Rev 6/95

Registrar

MAR 04

Agriculture to the second

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08325 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Ralph William MANUEL January 16, 1997 eer 3:47AM 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Desth Doctors Community Hospital Prince Georges Lanham If Undar 1 Year If Undar 24 Hrs. 8. Deta of Birth
Months Deys Hours Min. (Month Day, Year)
AUGUST 7, 1914 5. Sociel Security Number 9. Birthplace (Stata or Foreign 7. Age (In yrs. last birthday) **XX**M 2□ F 82 Yrs. Washington, D.C. 577-03-7044 Ususi Residence of Dacedent 10b. County 10c. City, Town or Location 10d. inside City Limits Prince George's College Park XX Yas 2 No 10f. Zip Code 20740 10g. Citizen of Whet Country?
United States 6100 Westchester Park Drive 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 14. Rece - Amarican indian, Bisck, White, etc. 1XOX es 2 □ No If Yes, Give Yaar or Datas: 1943–1946 1 Never Merried 2 Merried 1 ☐ Yas XX No Specify. White Specify: 3℃Widowad 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Printer Government. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Manuel Rose LaPorta 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code, 7223 Sunrise Drive Lanham, Maryland 20706 19e. informent's Neme/Reletionship (Type, Print) Sallie Loughery (daughter) 20b. Place of Disposition (Name of cematery, crametory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Burlel 2 Cremation 3 Removel from Steta 4 Donetion 5 Other (Specify) Resurrection Cemetery 1/20/1997 Clinton, Maryland 21. Signature of Funarai Sarvice Lice 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland20705 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory strest, shock, or heart feiture. List only one ceuse on each line. Approximate intervsi Between Onset and Deeth Due to (or as a consequence of): Sequentielly list conditions, if eny, leeding to immediate cause. Enter Undarfying Cause (Diseesa or Injury that initiated events rasulting in death) Lest Due to (or es e consequence of) Due to (or es a consequance of) Part II. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Pert I. 23b. Did tobacco use contribute to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to complation of ceusa of death? 24e. Wes sn eutopsy performed? 20 No 1 Yes 2 No 1 ☐ Yes 26. Piece of Deeth (Check only one) 2 ER/Outpetlent 3 DOA

Physician /Medicai Examiner

Box 68760.

Division of Vital Records, P.O.

Physician

/Medical

Examiner

10a State

Maryland

10e. Street end Number

Anthony

Immediate Cause (Final disease or condition resulting in deeth)

Funeral

Director

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ed other then "natural", or item event, the Medical Examiner.

Herms 23a

Pages 1 and 2 should be filed within 72 hours after death sent of Health and Mental Hygiens.
Int: If Item 27 is marked other than "natural", or Items 23.

and a Health a vit. If Itam 27 is vier of

Department of Important: If any injury or once.

Baltimore, Maryland 21215-0020

Director

Completed by Funeral

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the Maryland

Examiner and Completed by Physician/Medical USB certificate funeral director, this After

or Attending Physician: The law requires that the death certificate be executed ne Hospital or Attendin in 24 hours after death. The Funeral Director: Aft pletely filled in by the fur

> State Registrar

Be 25. Wes case referred to medicei exeminer? Hospital: 1 Thipatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes /2 No Certification: To 28e. Dete of injury (Month, Dey Year) 27. Mannet of Death 28d. Describe how injury occurred 28b. Time of 28c, injury et Work? 1 DeNatural 5 ☐ Pending 1 ☐ Yes 2 No investigation 2 Accident 3 Suicide 8 Could not be 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide 29s. Certifier 1 Certifying Physicisn: To the best of my knowledge, deeth occurred at the time, dete and plece, and due to the ceuse(s) end menner as steted. Medical On the basis of exeminetion end/or invastigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

In

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

Sveen Way

32. Registrar's 31. Dete filed (Month, Day, Year) JAN 1 7

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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Deeth Dey Month **Physician** ELFRIEDE MEINFELDER FEBRUARY 22, 1997 9:32pm /Medical 4a. Fecility Nama (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S CO. COMMUNITY HOSPITAL ANHAM-SEABROOK DOCTORS If Under 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) May 16, 19 7. Aga (In yrs. last birthdey) 5. Sociel Security Number Birthplece (State or Foreign Country) **Funeral** Deys 1 ☐ M 2 🕅 F 88 Yrs Director Germany 475-12-0811 Usual Residence of Decedent the Maryland r 28a-f show inotified at 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Prince George Mitchellville 10e. Streat and Number 10f. Zlp Coda 10g. Citizen of What Country? b the Medical Examiner must be Items 23s 3800 Lottsford Vista Road 20721 USA Funeral 12. Wes Decedant Evar In U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Giva Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 72 hours after 1 ☐ Never Merried 2 ☐ Married 'natural', or 1 ☐ Yas 2 No SpecifyWhite þ 3 N Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within vent of Health and Mental Hygiene. Int: if Nen 27 is marked other than "s Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Ferdinand Ucko Bertha Schiftan 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Routa Numbar, City or Town, State, Zip Code) Department of Health ar Important: if Nem 27 is any injury or other trau Freddy Sol Meinfelder 2915 Dover Lane #204, Falls Church, Virginia 22042 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Steta 20a. Method of Disposition Dete 1 ☐ Buriel 2 ☐ Cremetion 3 🕅 Removel from Steta Adath Yeshurun Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 3/4/97 Minneapolis, MN 21. Signeture of Funeral Service Licenses 22. Neme end Address of Fecility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Pert1. Enter the display shock, or heep to un List only one cause on each lina. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final - QC) ays disease or condition resulting in deeth) Examine Examiner the death certificate be executed Sequentielly list conditions, if eny, leeding to Immediate ceuse. Entar Underlying Cause (Diseese or Injury that Initiated events rasulting in deeth) Lest Due to (or es e consequence of): pue physician e 123 Physician/Medical Due to (or es a consequance of): for use es ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 □ Probably 4 □ Unknown 1 Yes 2 No by 24b. Were eutopsy findings evallebla prior to completion of cause of death? 24e. Was en eutopsy performed? Completed page 2 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director. Be 25. Wes cese referred to medicel examiner? 26. Plece of Deeth (Check only one) examiner? spitel: 1 Inpatient 2 ER/Outpetlent 3 DOA

28a. Date of Injury
(Month, Dey Year)

28b. Tima of Injury
(Month, Dey Year) Other: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) Certification: To this funeral 27. Menner of Deeth 28d. Describe how injury occurred 28c. Injury et Work? After 1 Netural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigetion ofter death Director: A 3 in by the f 6 Could not be determined 3 Sulcide Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide a Funeral Di Funeral Di pletely filled in 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner es steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated. 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29d. Dete signed (Month, Dey, Year) 415 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print) IV D. Montarez, UD-1300 mercautile Lane-

State Registrar

LIRO 31. Dete filed (Month, Day, Year)

FEB 2 5 199

32. Registrer's Signature eli d'audion harlall

Baltimore, Maryland 21215-0020

Box 68760,

Division of Vital Records, P.O.

State of Maryland / Department of Health and Mental Hygiene 08328 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Deta of Daath **Physician** Month MARCH MILDRED MARCHBANKS E. 1997 /Medical 4a. Facility Nama (If not institution, giva street and number 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HOSPITAL ZOHNS HOPKINS Baltimore None 5. Social Security Number if Undar 1 Yaar if Under 24 Hrs. 8. Data of Birth (Month, Day, Year) June 12, 1 6. Sex 7. Aga (In yrs. last birthday) Birthpiece (Stata or Foreign Country) **Funeral** Days 10M 20F Hours 212-28-0311 Yrs. Director 66 1930 Maryland Usuei Rasidance of Decedant 10a Stata 10b County 10c. City, Town or Location 10d. insida City Limits 28a-f show must be notified at 1 Tyas 2 NO No Directo Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 8 3723 Bonny Bridge Place Berns 23a 21043 United States Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ②No if Yas, Giva Yaar or Dates: Was Dacadant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Raca - Amarican indian, Biack, Whita, atc. filed within 72 hours after. Hygiene. ther than "natural", or her 1 ☐ Navar Married 2X Married 1 ☐ Yas 2 No Specify: þ Specify: 3 ☐ Widowad 4 ☐ Divorced White Completed 15. Decedant's Education (Spacify only highast grada complated) 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Coilega (1-4or 5+) permit, Pages 1 and 2 should be filled w. Department of Health and Mental Hygiens important: if frem 27 is married other that any Injury or other traumatic across sides. Key Punch Operator Life Insurance Co. 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Malden Surname) Milton Starr Estella unknown 19a. informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Susan L. Cernik/Daughter 3723 Bonny Bridge Place Ellicott City, MD 21043 20e. Mathod of Disposition 20b. Placa of Disposition (Nama of camatary, crematory or other place) 20c. Location - City or Town, Stata 1 Buriai 2 □ Cramation 3 □ Removel from State 3-4-97 Mt. View Cemeterv 4 ☐ Donetion 5 ☐ Other (Specify) Marriottsville, MD 21. Signetura of Funarai Service Licensea 22. Name and Address of Facility
Harry H. Witzke Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Entar the disaasa, or compilections that caused the deeth. Do not anter the mode of dying, such as cardiac or respiretory errast, shock, or heart failure. List only ona causa on aech lina. Approximata intarvai Between Onset and Death **Physician** /Medical immediate Causa (Finai 2 days HY POTENSION disaasa or condition resulting in daath) Examiner Dua to (or as a consequanca of): Examiner MULTI - SYSTEM ORGAN buriel-transit pue Sequentially list conditions, if any, laading to immadiate causa. Entar Underlying Couse (Diseasa or injury that initiated events rasulting in daeth) Last Dua to (or es a consaguança of): physician s the burie HYPOXIA Physician/Medical Dua to (or as e consaquanca of) L MPHYSEMA 30 years Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did lobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown þ sign be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? page 2 this certificate 1 Yas 1 ☐ Yas 2 No director, Be 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) exeminar? Other: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) P 1 Yes 2 No 1 Tinpatiant 2 □ ER/Outpetient 3 □ DOA s efter deeth.

N Director: After this led in by the funerel d 27. Mannar of Deeth 28a. Data of injury (Month, Day Year) 28b. Tima of 28c. fnjury at Work? 28d. Dascribe how injury occurred 5 Panding investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 ☐ Accidant 6 Could not be datermined 3 Suicida 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At home, farm, straat, factory, office building, atc. (Spacify) 4 Homicide To the Hospital c within 24 hours of To the Funeral D completely filled 12 Certifying Phyefcfan: To the best of my knowledga, daath occurred at tha tima, data and piace, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at the tima, data and piace, and due to the causa(s) and manner stated. 29a, Cartifia Medical (Check only one) 29b. Signatura and title of certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) MO RES-001 10 30. Nama and addrass of person who complated causa of death (itam 23a) (Type, Print) JOHNS HOPKINS HOSPITAL, BALTIMORE, CHAN 31. Data filad (Month, Day, Yaar) 62. Ragistrar's Signeture State MAR 0 4 1997

Registrar **DHMH 16 Rev 6/95**

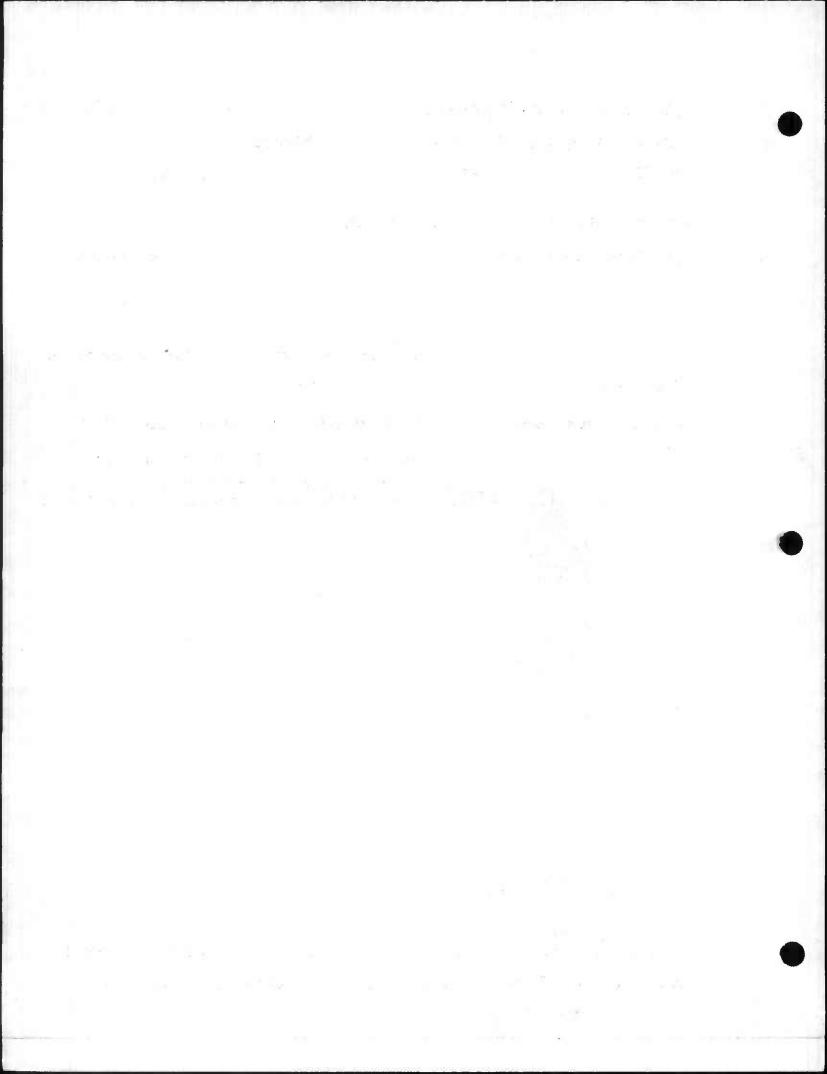
altimore, Maryland 21215-0020

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital or Attending Physician:



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

08329

3. Time of Death

25

Physician	
/Medical	
Examiner	

1. Decedent's Name (First, Middle, Last)

MILDRED FERN 4e. Fecility Name (If not institution, give street end number)

Month MARCH 4b. City. Town, or Location of Deeth

6 pm 4c. County of Death

Harford

USA

Funeral

5. Social Security Number 403-38-7196

1□ M 2√X

Fallston General Hospital

7. Age (In yrs. last birthday) Yrs 65

Fallston If Under 1 Year Months Days Hours

If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Day, 3/9/31

2. Date of Deeth

 Birthpiace (State or Foreign Country) Kentucky

Director

28a-f show b 72 hours after

the Medical Examiner must be notified at "natural", or items 23a. permit. Pages 1 and 2 should be filed within 2 bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than 19

Maryland 21215-0020

Saltimore.

Box 68760.

Records, P.O.

Division of Vital or Attending Physician:

Priyaiclar /Medical Examiner

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Physician/Medical Examiner physician and the burial-tran þ Completed peed certificate Be Certification: To As Hospital or A...
7-24 hours after death.
7-31 Director: After
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1-4-1 After To the Hospital or within 24 hours aft. To the Funeral Discompletely filled in

10a Stete Director 10e. Street and Number Funeral 1 Never Married 2 Narried þ 3 ☐ Widowed 4 ☐ Divorced Completed Elementary/Secondary (0-12)

Usual Residence of Decedent 10b. County York PA

10c. City. Town or Location

Delta

10f. Zip Code

17314

10d. inside City Limits 1 Yes X No 10g. Citizen of What Country?

67 Chestnut Oak Trail

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2000 If Yes, Give Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, spacify Cuben, Mexican, Puerto Rican, etc.) 1 □ Yes ₩No

14. Rece - American Indian, Black, White, etc. SpecifiWhite

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Dudley Hughes 18. Mother's Neme (First, Middle, Maiden Surname)

Nettie Brewer 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, Stete, Zip Code)

19a. Informant's Neme/Relationship (Type, Print)

67 Chestnut Oak Trail, Delta, PA 17314

Kenneth E. Morton-husband 20a. Method of Disposition

20b. Place of Disposition (Neme of cemetery, crematory or other place)

Homemaker

20c. Location - City or Town, State

XXBurial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

Slate Ridge Cemetery 3/8/97 Delta, PA

21. Signature of Furnierel Servica Licenses

22. Name and Address of Fecility
Harkins Funeral Home, Inc. 600 Main St., Delta, PA 17314

Main St., Delta, PA

The Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, ock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

Due to (or es a consequence of): ASTHMA HRONIC BRONCHIAL Due to (or as a consequence of):

RESPIRATORY FAILURE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest

Diabetes Mellitus Rependent

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ARTHRITIS WITH OSTEOPOROSIS 23b. Did tobacco use contribute to the cause of death?

ARDIAC ARRHYTHMIA

24e. Wes en autopsy performed?

1 Yes 2□ No

24b. Were autopsy findings eveileble prior to completion of cause of deeth?

1 ☐ Yes 2 ☐ No

3 Probably 4 Unknown

25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital:

1 Yes 2N No 27. Manner of Death 1 Netural 2 Accident

3 Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be determined 28e. Date of Injury (Month, Day

Inpatient 2 ER/Outpetient 3 DOA 28b. Time of

28c. tnjury et Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) Certifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end title of certifier

29c. License number MD-D18779

29d. Date signed (Month, Day, Year)

who completed cause of deeth (Item 23e) (Type, Print)

1800 HARFORD ROAD. FALLSTON, MD 21047 SUN, MD

State Registrar 31. Date filed (Month, Day, Year) WAR 7 1997

74 A 4

the state of the s

State of Maryland / Department of Health and Mental Hygiene 97

					Ce	ertificate	of	Death			Reg. No.		
Physic	ian	Decedent's Nama (First, Michael Land)		100					- 1	2. Data of Da Month		Yaar	3. Tima of Death
/Med	ical	LUCILLE	MARY		TSON					MARCH	3	1997	11:30 A.M
Exami	ner		Memorial	Hospit				Havr	e de	Grace		Harf	ord
Funeral Director		5. Social Sacurity Number 231-46-6047	6. Sax 1 ☐ M 2 💢 F		yrs. last birthday 83 Yrs.		Yaar Days	If Undar 2 Hours	4 Hrs. Min.	8. Data of Bird (Month, Da 10-30-	1913	9. Birthp Coun	olaca (Stata or Foreign otry) VA
Sow M		Usual Rasidance of Dacedant 10a. Stata 10b. Cour	nty	10c.	. City, Town or L	ocation						1	0d. Insida City Limits
the Many 28a-f sh sptiffed	Director	MD 10e. Street and Number	n/a			Balt		ore			10 011		1M Yas 2 No
death with the Maryland rits 23s or 28s-f show Linust be notified at			entridge F			10f. Zip C	2	1239		74		of What Cour	try?
3 2 2	by Funeral	. 11. Marital Status 1 □ Navar Married 2 □ M 3 ☑ Widowed 4 □ Divorc	Armed f arriad 1 ☐ Yas	a 2 X No Giva	in U,S. 13.	Was Daceda If Yas, specif		lispanic Orlgi an, Maxican, Specify:	in? (Spec Puarto R	cify Yas or No Ricen, atc.)		Race - Amaric Black, Whita, ecify: Wh	
d within 72 hours all glene. If than "natural", or the Medical Exam.	Completed	15. Daced (Specify only high	ant's Education hast grada complatac	d)	16a. Dece	edant's Usual	Occup dona	ation during most o	of workin	a	16b. Kind o	of Business/Inc	Justry
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STAT		17. Fathar's Nama (First, Middl	a. Last)			поп	nem	aker	's Nama	(First, Middle,	Maidan Sun	Home	
d 2 should be file th and Mental Hy 7 is marked othe traumatic event.	To Be		s Earle Ca	arner,	Sr.			TO. WOLTER		ry Fer		,	
	-	19a. informant's Name/Ralatio				ing Addrass (or Rurel	Routa Numbe	or, City or To	wn, Stata, Zip	'
는 보고 등 등		20a. Mathod of Disposition 1 ☑ Buriai 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other			b. Place of Disp cematary, cra Mt. Zic	matory or oth	ar piac		3	Data / 7 / 9 7		on - City or To	ivn, Stata
permit. Page Department of Important. If any Injury or gase.		21. Signature of Funaral Sarvio	ce Licenses	2	-	2. Nama and Mitcl	Addra	ss of Facility	h Fu	neral		P.A.	
beth certificate be executed // Medical extending physician and for use as the burial-transit	an/Medical Examiner	23a. Part1. Enter the disease, shock, or heart fallure. Li Immediata Causa (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate causa. Enter 'Inderlying Causa (Olsease or Injury that initiated evants resulting in death) Last	bS cd	Due to Cope to	aley of (or as a correct Ne (equance of): One of the control of	Why	Les thin	, Na				Intarval Batween Onset and Death
a deeth the etter	Physician	Part ii. Other significant condi	tions contributing to	death but not	rasulting in tha	undariying cau	ısa giv	an in Part I.		23b. Did t	obacco use	contribute to	the cause of death?
that the de sed by the e										101	/es 2□ N	o 3 D Prot	bebly 4 Unknown
The law requires the cate has been signed; pege 2 should be to	Completed by									24a. Was perfor	med?	cor of c	are autopsy findings aliable prior to mplation of cause death?
Physician: The this certificate ral director, per	Be	25. Was casa refarred to medic axaminar?	Hospital: 1	/			Oth	or.		(Check only o			
Iling I. After fune	ation: To	1 Yas 2 No 27. Manyar of Death Natural 5 Pand 2 Accident invas	28a. Data	HI VALLEY VALLEY	2 ER/Outpatie 28b. Tima o injury		. Injun	4 LI NUIS	28	a 5 ☐ Rasid 8d. Dascribe h)
2 4 4 5	Certification:	3 ☐ Suicida 6 ☐ Coule	mined Zoa. Flac	ce of Injury - A ding, atc. (Spa	t homa, farm, st	reet, factory, o	office		28	Bf. Location (S City or Tow		im <i>ber</i> or Rura	l Routa Number,
To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Cartifiar (Check only one) 1 Cartify 2 Madica	ing Physician: To the line Examinar: On the line and man	a best of my le basis of axam nnar stated.	knowladga, daat ination and/or Ir	th occurred at avastigation, in	tha tim	na, data and pointing	place, an	nd dua to tha d d at tha tima, d	eusa(s) and lata and plac	mannar as st. ce, and dua to	ated. tha causa(s)
To the To the Complex	2	29b. Signature and tipe of certif	ler .	L	M	29c. L	icense	number 206	6		29d. Data sig	gned (Month, I	Day, Year)
	-	30. Name and address of perso	ee M	D.	(Typ6	Fint) Per	ol	utio	u S	A. 6	farre	de 6	race ML
Sta Registr	_	31. Data filed (Month, Day, Yaa	1997 32	Registrar's Si	gnatura	M						2	1078:

State of Maryland / Department of Health and Mental Hygiene 0.7

						Cer	tificate	of	Death			Reg. No.	1	08331
	ъ.		1. Decedent's Neme (First, Middle, La	est)							2. Dete of De Month	eath	V	3. Time of Death
	Physic /Medi		William Mc	Gowan							Marc	h 3rd 1	Year 1997	08=51Hr
З	Exami		4e. Fecility Name (If not Institution, given		r)				4b. City, To	wn, or Lo	cation of Deel			
			804 Philadelph						Abin				larf	
ı	Funeral Director		080-18-7725	Sex 7. A 125 M 2□ F	ige (In yrs. lest bi 71	rthdey) Yrs.	If Under 1	Yeer Deys	Hours	24 Hrs. Min.	8. Dete of Bi (Month, D July 2	th Year) 26, 1925	9. Birthi Cour New	piece (State or Foreign otry) York
П	B		Usuel Residence of Decedent 10e. Stete 10b. County		10c. City, Tow	m or Lov	cation						1.	Od. Inside City Limits
	f sho	ō	Maryland Harfo	~~3										1 ☐ Yes 2 HNo
	28 gg	Directo	10e. Street end Number	Id	Abin	igaoi	10f. Zip C	ode				10g. Citizen of	What Cou	
	death with the Maryland rns 23a or 28a-f show crnst be notified at	rai Di	804 Philadelphia						21009			J	JSA	
0000	alf, or he Examine	by Funeral	11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Deceden Armed Forces 1 ☒ Yes 2 ☐ If Yes, Give Year or Detes	?) No WWTT		Vas Deceder Yes, specify	-		gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	Specif	ck, White,	can Indien, etc. Thite
Maryland 21215-0020	within 72 ens. than "na he Medio	Completed	15. Decedent's E (Specify only highest gn Elementery/Secondery (0-12)	ducation ede completed) College (1-4or		(Give I	ent's Usuel (kind of work of OO NOT use Steamf	done retire	during most d)	of worki	ng	18b. Kind of B	usiness/in	
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	and 2 path a 27 is ar tra		Dorothy McGowan	- Wife	8	04 I	Philad	elp	phia A	ve.	Abing	don, Md	. 210	09
Baltimore,	Pages 1 and lent of Healt nt: If Ilam 2 ry or other		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specia		9 .	ny, crem	etory or other	er ple		lone	Dete 3-5-97	20c. Location		own, Stete Maryland
Baltin	pormit. Pages 1 and Department of Health Important: If Item 27 any injury or other to odice.		21. Signature of Funeral Service Lice	V -	111911	22. HC	Neme end /	Addre K.	ss of Fecility McCon	as]	II Fun	eral Hordon, Md	ne, P	.A.
	Physician /Medical Examiner		23a. Pañ1. Enter the disease, or com shock, or heert fellure. List only Immediete Cause (Finel disease or condition resulting in deeth)		the death. Do line.	not ente	er the mode o	of dylr	ng, such es	cardlec d				Approximete Intervel Between Onset end Deeth
	pe jist	Examiner		ASCVD	Due to (or es e	conseq	uence of):						į	
90,	se execution and suriel-trans		Sequentially list conditions, if any, leading to immedlete cause. Enter Underlying Cause (Disease or injury that initiated events	0	Due to (or es e	consequ	uence of):							
ox 68760,	requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the buriet-transit	VMedical	thet Initiated events resulting in death) Lest	d	Due to (or es e	consequ	uence of):							
Bo	atter d for u	clar	Dort II. Other elevident conditions	and allowed in the second of			al calcalana and a				1 001 014	A		
P.O.	res thet the de igned by the	/ Physician/	Pert II. Other eignificant conditions of	onthouting to death	out not resulting i	n the un	derlying cau	se giv	en in Peπ I.			Yee 2 No		the cause of death? bebly 4 🗆 Unknown
Records,	2 S S	Completed by									24a. Wes	s en eutopsy ormed?	av	ere autopsy findings allable prior to mpletion of cause deeth?
E	The ate h	5									10	Yes 2 DNo	1[Yes 2Ñ No
Vital	Physician: The this certificate rel director, par	Be	25. Wes case referred to medical exeminer?							of Deeth	(Check only	one)		
of	this c	은	f Yes 2 No	Hospitel: 1 ☐ Inpat				Oth	4 LI INU			idence 6 DOtt		y)
no	D 2 2	io io	27. Manner of Deeth ↑ ☑ Neturel 5 ☐ Pending	28e. Dete of Inj (Month, D	ey Year) 28b.	Time of Injury		. Injur Wor			28d. Describe	how injury occur	red	
Sic	Attending in death.	Icat	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not b	AVI	njury - At home, fe	NA	M factors o		Yes 2 💢		ORF Location	N A Street and Num!	ner or Pur	of Poute Number
Division	i or Attendir efter death. Director: Al	Certification:	4 Homicide determined	building, e	tc. (Specify)	N A	et, rectory, o	mice				wn, Stete)	Joi Oi Mari	irriodio ridilibor,
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			30. Neme and eddress of person who G.S.Prabhu M.D	.1810 Be	elair R	d #	102	Fa	allst	on	MD. 2	1047 41	0-8	79-6564
	Sta Registr	-	31. Dete filed (Month, Dey, Year) MAR 0 5	1997 32. Regist	rer's Signature	Reso	lett.							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08332 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Deeth MELVIN MARCH 1997 4a. Facility Neme (If not institution, give street end number 4b. City, Town, or Location of Death 4c. County of Death Prince George's General Hospital Cheverly Prince George's 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) Months 1 € M 2 □ F 54 239-66-7857 Usual Residence of Decedent North Carolina August 10, 1942 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Capital Heights Maryland Prince George's 1 ¥ Yes 2 □ No 10g. Cltizen of What Country? 10e. Street and Number 10f. Zip Coda 20743 6318 Martin Luther King Jr. Highway 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, Black, White, etc. 1 Yas 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grede completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Library of Congress Sheet Metal Technician 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Elvia Jackson Martin McNeil 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Jovae McNeil Wife 6318 Martin Luther King Jr. Highway, Capitol Heights, Maryland 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State March 7, 4 ☐ Donation 5 ☐ Othar (Specify) Harmony Memorial Park Landover, Maryland 1997 21. Signature of Funeral Service Licer 22. Name and Address of Facility 20608 Adams Funeral Home, 20605 Aquasco Road, Aquasco, Maryland 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiratory errest, shock, or hear deliure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Immediate Cause (Final My O CARD IN TWPHICTION
Due to (or as e consequence of): 10-15'MINUL disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest DISFASE Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of ceuse of death? 24e. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28d. Describe how injury occurred

pue physician s the burial Box 68760. PO he signed by a Vital Records, of Division Attending effer death.

Director: Afferd in by the fun

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within 24 hours of To the Funeral Completely filled

Physician/Medicai À Completed Be 10

Examiner

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permit. Pages 1 and 2 should be f Department of Health end Mental F Important: If Item 27 is marked of any Injury or other traumatic eve

Physician /Medicai

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Baltimore, Maryland 21215-0020

Examiner must be notified at

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Medicai Certification: 11 DNatural 2 Accident 3 ☐ Suicide 4 Homicide

29a, Certifier

25. Was cese referred to medicel examiner? 1 Yes 2D No 27. Manner of Death

5 Pending Investigation

6 Could not be determined

28b. Time of

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 Certifying Phyalclan: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) end menner steted. 29b. Signature and title of certifier

31. Date filed (Month, Day, Yeer)

29c. License number 25766 29d. Date signed (Month, Dey, Year)

30. Nema and address of person who completed ceuse of death (Item 23a) (Type, Print)

State Registrar

32. Registrar's Signature

Talia Staveles Redall

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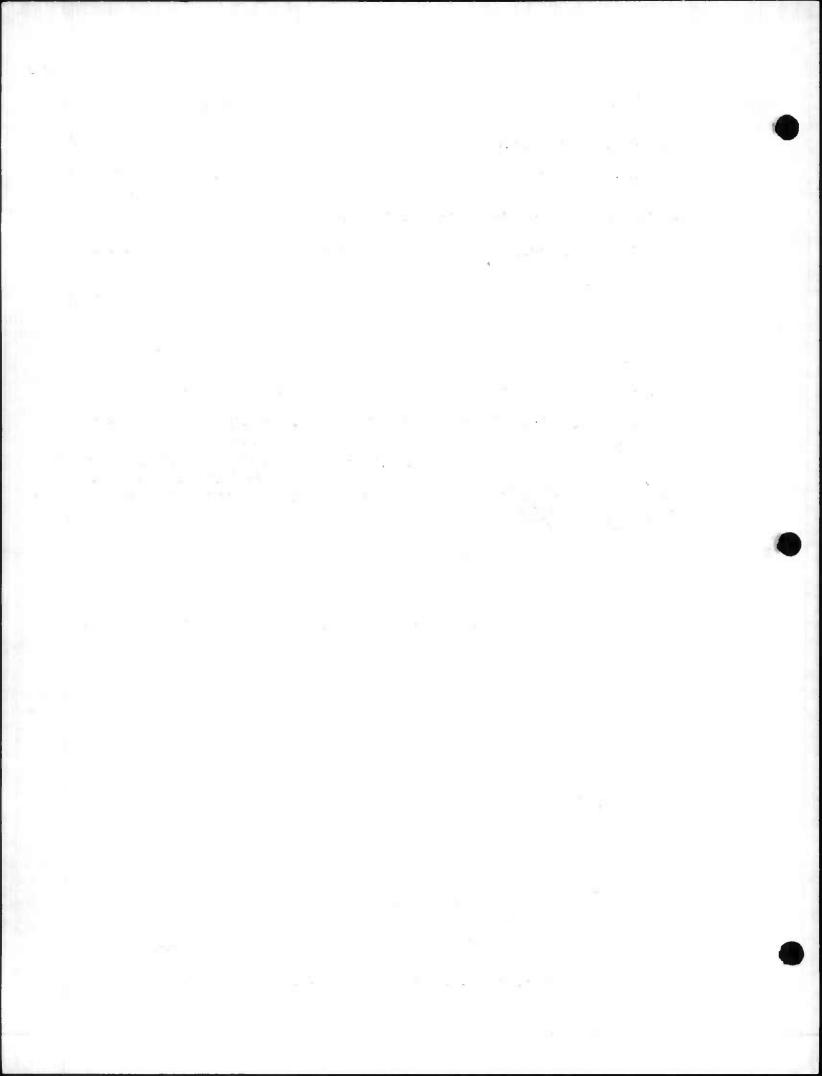
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month March 5,1997 **Physician** Ruth Elmira Mills 6:00PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Prince George's Prince George's Medical Center Cheverly 5. Sociel Security Number 6. Sex 1**X** M 2□ F 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 9. Birthplece (State or Foreign **Funeral** Hours Virginia Director 577-22-2741 Usuel Residenca of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Items 23s or 28s-f show Maryland Prince George's Capitol Heights 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 20743 521 Ashleaf Avenue Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. trsumatic event, the Medical Examiner filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates: 21215-0020 ò 1□ Yes 2 No White by Specify: 3 Widowed 4 Divorcad "naturs!" Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) Coilege (1-4or 5+) Home 12th N/AHomemaker other Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Pages 1 and 2 should be fill ment of Health and Mental Hants I is marked othory or other traumatic even Be Finks Eula 2 Ward Lark 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 521 Ashleaf Ave. Capitol Heights, Md 20743 Gregory N. Mills (Husband) 20b. Pleca of Disposition (Neme of cemetery, cremetory or other placa) 20e. Method of Disposition 20c. Location - City or Town, Stete March 10. 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removal from State Department o Important: If any injury or 1997 4 ☐ Donetion 5 ☐ Other (Specify) Clinton, Maryland Lee Crematory 21. Signature of Funeral Service Licens 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md20735 above thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, puise on each line. Intervel Between Onset end Deeth **Physician** immediete Cause (Finel diseese or condition resulting in death) /Medical anoxic Examiner Due to (or es e consequence of): Examiner Dreumonea The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, Physician/Medicai Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 3 Probably 4 Unknown signed by 1 Yss 2 No à pe 24b. Were eutopsy findings aveileble prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 2 Ne 1 ☐ Yes 2 ☐ No al or Attending Physician: The safter death.

I Director: After this certificate funeral director. 25. Was case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Hospitel: 1 Yes 2 No 1 Impetient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpetlent 3 DOA 27. Menner of Peeth 28d. Describe how injury occurred 28e. Date of injury (Month, Dey Year) 28b. Time of 28c. injury et Work? 1 Maturei 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral DI completaty filled in 🗓 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pieca, end due to the ceuse(s) end menner as steted. Medical 29a. Certiflei 2 Medicat Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pieca, end due to the ceuse(s) end menner stated. 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dev. Year) March 8 ,1997 30. Name and address of person who completed carge of death (Item 23e) (Type, Print)

Lynne Perry-Bottinger M.D. 7350 Van Dusen Rd. # 450 Laurel, MD 20707 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State whi Swilson Radall Registrar MAR 1 1

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State of Maryland / Department of Health and Mental Hygiene

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Ī	Funeral Director		5. Social Security Number 232-44-9471	6. Sax 1 □ M 2)∑ F	7. Aga (In yrs. 71	last birthday) Yrs.	Months Day	ar If Under	r 24 Hrs. Min.	8. Data of 8 (Month, D		9. Births	olaça (Stata or Foreign
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			30. Nama and address of person Gerardo Gacad,	who completed caus MD 6510	a of death (item Kennilwo	23e) (Type, orth A	Print) ve, Suit	te 2700	0, Ri	iverdal	e,Md		177
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		n, give street and nu					t	21	1997	6:08AN
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1	5. Social Security Number 577 - 76 - 8545	6. Sex 1)X□M 2□F	7. Age (In yrs. 38	iast birthday) Yrs.	If Under 1 Yea Months Days		Ain. (Month, L	orth Say, Year) 8-1958	9. Birthr Cour Was	place (State or Foreign http: nington DC
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	medical continued by Funeral Director	Maryland Prince 10e. Street and Number 5408 76th 11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced (Specify only highe Elementary/Secondary (0-12) 15. Deceder Donald Jef 19a. Informant's Name/Relations Miriam Mason/Ma	10a. State Maryland Prince George 10a. Street and Number 5408 76th Court 11a. Marital Status 12. Was Determined 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1+17. Fethar's Name (First, Middle, Last) Donald Jefferson Main Mason/Wife 20a. Method of Disposition 1 (XBurial 2 Crametion 3 Removel from 4 Donation 5 Other (Specify) 21. Iforature of Fundral Service Licenses 23a. Pert1. Enter the disease, or complications that shock, or heart failure. List only one cause on included a shock, or heart failure. List only one cause on including in death) Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that inside events resulting in death) Part II. Other significant conditions contributing to death Cause (Disease or injury that inside events resulting in death) 25. Was case referred to medical examiner? 26. Was case referred to medical examiner? 27. Manner of Death Natural of Could not be detarmined a cause (Chieck only one) 28a. Date (Monator of Could not be detarmined) 29b. Signeture and title bit certifier 30. Name and address of person who completed cause (Disease of person who c	10a. State Maryl and 10b. County Prince George's 10c. Cit Maryl and 10b. County Prince George's 10c. Cit Maryl and 10c. Cit Maryl and 10c. Cit Maryl and 10c. Cit Maryl and 10c. Cit Maryl and 10c. Cit Maryl and 10c. Cit Maryl and 10c. Cit Maryl and 10c. Cit Maryl and 10c. Cit Maryl and 10c. Cit Maryl and 10c. Cit Maryl and 10c. Cit Prince George's 10c. Cit Maryl and 10c. Cit Prince George's 10c. Cit Maryl and 10c. Cit Prince George's 10c. Cit Maryl and 10c. Cit Prince George's 10c. Cit Maryl and 10c. Cit Prince George's 10c. Cit Armed Forces? 11. Was Decedent Ever in U Armed Forces? 11. Cyse, City Very College (1-4or 5+) 1	10a. State 10b. County Prince George's 10c. City, Town or Low 10c. Street and Number 5408 76th Court	10a. State 10b. County 10c. Caly, Town or Location 14ya 10a. Street and Number 10d. Zp Code 10d.	10a. State 10b. County 10c. City, Town or Location 10f. Zip Code 20784 10c. Street and Number 5408 76th Court 10f. Zip Code 20784 20784 2078	Name Company Prince George's 10c. City, Town or Location Hyattsville	10. Series and Number 10. County 10. City, Town or Location 10. Zp Code 20784 10. City Code 10. Zp	Use It Residence of Decoder! 10s. Street and Number Disc. Count 10s. Street and Number Disc. Count 10s. Street and Number Stock 10s. Malling Address Street and Number Street 10s. Malling Address Street and Number Street 10s. Malling Address Street and Number Street 10s. Malling Address Street and Number Street 10s. Malling Address Street and Number Street 10s. Malling Address Street and Number Street 10s. Malling Address Street and Number Street 10s. Malling Address Street and Number Street 10s. Malling Address Street and Number Street 10s. Malling Address Street and Number Street 10s. Malling Address Street and Number Street 10s. Malling Address Street and Number Street 10s. Malling Address Street and Number Street 10s. Malling Address Street and Number Street 10s. Malling Address Street and Number Street 10s. Malling Address Street and Number Street 10s. Malling Address Street and Number Street 10s. Malling Address Street 10s. Malling Address Street and Number Street 10s. Malling Address Street 10s. Malling Address Street 10s. Malling Address Street 10s. Malling Address Street 10s. Malling Address Street 10s. Malling Address Street 10s

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month ROULLETTE H. McNEAL February 26, 1997 8:00 a.m /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 4133 URN STREET Capitol Heights Prince George's 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1₩ M 2□ F Months Deys Hours Yrs. 578-24-2983 **Director** Nov. 25, 1925 Washington, D.C. Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits the Maryla r than "natural", or thems 23s or 28s-f show the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Prince George's Capitol Heights 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 4133 Urn Street 20743 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Giva Yeer or Detes; Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, 11. Maritei Stetus Bleck, White, etc. 1 Never Merried 2K Married Baftimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: p Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation
(Give kind of work done during most of working
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Retired 16b. Kind of Business/Industry Hygiana. Elementary/Secondery (0-12) College (1-4or 5+) Retired Assistant Warehouse Manager permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy, Importants if Nem 27 is marked other any injury or other. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Robert McNeal Elizabeth Jones 19e. Informent's Neme/Raletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Vivian L. McNeal Wife 4133 Urn Street, Capitol Heights, MD 20743 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) Dete 20c. Location - City or Town, Stete 1 ₺ Buriel 2 □ Cremation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 3/3/97 Mt. Olivet Cemetery Washington, D.C. 21. Signeture of Fuperel Service Licenses 22. Name end Address of Fecility STEWART FUNERAL HOME, Inc. PM. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,

Applications are completed by the deeth of the deeth Approximeta Intervel Between Onset end Deeth **Physician** /Medical Immediete Cause (Final cancer of diseese or condition rasulting in deeth) 18 mos Examiner Due to (or es a consaquence of) be executed Sequentielly list conditions, if eny, leeding to immediate cause. Entar Underlying Ceusa (Disaasa or injury thet initiated events resulting in deeth) Lest pue Due to (or es e consequence of): Box 68760 Physician/Medical the Due to (or es e consequence of): attending p 98 P.O. | Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t Unknown 1 Yes 2 No 3 Probably Records, by 24b. Were eutopsy findings evellable prior to completion of ceuse of deeth? Completed 24e. Wes en eutopsy performed? page 2 s 2 110 certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: efter death. 25. Was case referred to medical Be 26. Plece of Deeth (Check only ona) 2 Other: 4 Nursing Home State Nesidence 8 Other (Spacify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Data of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: After 5 Pending Investigation 1 Naturar 2 Accidant Natural efter death.

Director: Aft
d in by the fur 1 Yes 3 Suicide 6 Could not be datermined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 - Homicide Hospital hours Funeral Medicai 29a. Certifier Certifying Phyeician: To the best of my knowledga, daath occurred et the tima, data end plece, end due to the ceuse(s) and manner as steted. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) end menner stated. To the How within 24 h To the Fur completely 29b, Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) DZZZYZ manin O. Weltzm 30. Name end eddress of person who completed ceuse of deeth (item 23a) (Type, Print) MARTIN D. WELTZ greamay a Onuse greenbest MD 2000 7525 32/Registrar's Signeture 31. Date filed (Month, Dey, Year) State Registrar MAR 03 1997

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Physicia /Medic Examine

Funerai Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantel Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any Injury or other traumatic event, its Mexical Examination must be nearlest

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

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MARYLAND PRINCE O	FORGES	CLIN	MOM									Yas 2[
10e. Street and Number) DOTO BO	CELIT		p Code				10a	Citizen of	What Cou	ntry?		
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11. Marital Status	12. Was Decedent Ev	ar in U.S.	13. Was Dece	dent of h	Hispanic Ori	igin? (Sp	ecify Yes or N			ce - Ameri	can India	n.	
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15. Decedent's E	ducation	16a.	Decedent's Usu	al Occup	pation			16b	Kind of B	usiness/in	ndustry		
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17. Father's Name (First, Middle, Last NORMAN B. MITCHE						er's Name	e (First, Middle DE BUT			ne)			
19a. Intormant's Name/Relationship ((Type, Print)	19b	. Mailing Addres	s (Street	and Numbe	er or Rur	al Route Numi	ber, Cit	y or Town	, State, Zij	Code)		
CAROLYN MITCHELI	L/WIFE	57	703 GWYN	NDAI	E PL.	CLI	NOTON,	MD	2073	35			
20a. Method of Disposition			Disposition (Na	me of			Data	200	Location	- City or To	own, Stat	ө	
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To the Hospital or Attending Physician: The law requires that the death cartificate be associated within a hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the buffartransit Division of Vital Records, P.O. Box 68760,

> State Registrar

29b. Signatura and titla of certifiar

30. Name and address of person who completed causa ot death (#### 234) (Type, Print)

Strphen S. Radentz, 31. Data tiled (Month, Day, Year) MAR 04 1997 MD 111 Penn Street, Baltimore, Maryland 21201
Ragistrar's Signature

29c. Licansa number

O.C.M.E.

29d. Date signed (Month, Day, Year)

FEBUARY 28,1997

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O. 7

		Certificate of Death 1. Decedent's Name (First, Middle, Last)		Reg. No.	08339
Physic /Medi	ical	IVATURY MURTHY	Month 2	Z 8 9	7 11:20 PM
Exami	ner	LAUREL REGIONAL HOSPITAL LAURE	L		NCE GEORGES
Funeral Director		5. Social Security Number 027-26-2939 12 M 2 F 7. Age (In yrs. last birthdey) 15 M orths Deys Hours Min	8. Date of Bir (Month, De 8 – 2 2	th ly, Year) 2-1924	B. Birthpleca (Stete or Foreign Country) INDIA
fanyland show ed at	20	10e. Stete 10b. County 10c. City, Town or Location			10d. inside City Limits 1♥ Yes 2 □ No
ith with the Marylar 23e or 28e-f show unt be notified at	Funeral Director	MD PRINCE GEORGES BOWIE 10e. Street end Number 8503 SHELLEY CT. 10f. Zip Code 20720		10g. Citizen of Who	
lar dea	by Fune		pecify Yes or No to Rican, etc.)	14. Rece - Bleck, Specify:	Americen Indien, White, etc.
21215-0020 4 within 72 hours at plane. Then "naturel", or then "naturel", or the Medical Exam	Completed		rking	16b. Kind of Busin	
Maryland 2 d 2 should be filled ftr and Mertal Hygi 7 is marked other fraumatic event, I	To Be Co	17. Fether's Neme (First, Middle, Last) 18. Mother's Nei	me (First, Middle, YAMA VI	Maiden Sumeme)	
Ore, ges 1 and if New 2 or other		19e. Informent's Neme/Reletionship (Type, Print) VIJAY IVATURY SON 20a. Method of Disposition 1 □ Burlel 2 □ Cremetion 3 □ Removel from Stete	Y. #21 Dete	ALEXAND 20c. Location - Ci	ORIA, VA 223 ty or Town, Stete
Damit. Pages 1 a Department of Hes Important: If hem any injury or othe strice.		4 Donetion 5 Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility AUSTIN ROYSTER 3821 14TH ST.	FUNERA N.W. WA	AL HOME ASH. DC	
Physician /Medical Examiner		23a. Fert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardier shock, or heart fature. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) e	c or respiratory e	rrest,	Approximate Interval Between Onset and Death
BOX 06/00, eath certificate be executed attending physician and I for use as the burial-transit	n/Medical Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Lest b. ACUTE MYOCARDI AL INTARCTO Due to (or es e consequence of): COVENARY AVIETY DISEASE. Due to (or es e consequence of):	ι.		72 hrs. 5 years.
hat the death ad by the atte	Physician/N	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.			ibute to the cause of death?
law requires that the death certain signed by the attending 2 should be delached for use	by		24e. Wes		Probably 4 Unknown 24b. Were eutopsy findings eveilable prior to completion of cause
The law ate has b	Completed		101	res 2 No	of deeth?
Or VIIdi neconds, Physician: The law requires the tribic certificate has been signed and director, page 2 should be	To Be	25. Wes cese referred to medical exeminer? 1 Yes 2 No		dence 6 Other	
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	1 Neturel 5 Pending (Month, Dey Year) Injury Work? 2 Accident 3 Suicide 4 Homicide	28f. Location (S City or Тои		or Rural Route Number,
ne Hospital n 24 hours i ve Funeral I	edical Ce	29e. Certiflier (Check only one) Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end plece 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end plece 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, determiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, determiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, determiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, determiner: On the basis of examination end/or investigation end/or investigation.	, end due to the orred at the time,	ceuse(s) end menn dete end plece, end	er es steted. Id due to the ceuse(s)
To the within To the Comp	M	29th Signature William 29c. License number D 19252		29d. Dete signed (# 2 - 2 8	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERTO A DEPETRIS MD. 14300 GALLANT FOX LA A	=122 B1	rwie MJ	2075
Sta Registr	100	31. Dete filed (Month, Dey, Year) NAR 04 1937.			

DHMH 16 Rev 6/95

in .

		per FH FilmG746 4-8-9	State of Marylan	Certi	ficate of	Death	Torrital (1)	Reg. No.	37 08340
Physici /Medio		1. Decedant's Nama (First, Middla, Las. Albert Peter	Mc Graw	TIL			2. Data of Do Month March	Day	Yaar 8'10 A m
Examir Funeral Director		4a. Facility Name (If not institution, giva Anne Arunde) 5. Social Sacurity Number 6. Sa	street and number) Redical Cen			4b. City, Town, or Lo Annual Office If Under 24 Hrs. Hours Min.	S 8. Data of Bi (Month, Di	Anne	of Death Arungel 9. Birthplaca (Stata or Foraign Country)
show dat		10a. Stata 10b. County	10c. City	y, Town or Local	tion				10d. Inside City Limits
the Mar 28a-f st notified	Director	Maryland Anne Ar	undel	Crofton					1 □ Yas 🏝 No
with a		10e. Straat and Number			10f. Zip Coda			10g. Citizan of	What Country?
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2 hou stural ical E		15. Decedant's Edu	cation	16a. Decedan	t's Usual Occup	ation		16b. Kind of B	will Le
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Sould be fill anriced oth marked oth	To Be	17. Fathar's Nama (First, Middla, Last) Albert P. McGraw				18. Mother's Name	Beck		
od 2 st Ilb and 17 is n tream		19a. Informent's Name/Ralationship (T) Marie B. McGraw	pa, Print) Mother			and Number or Run			Stata, Zip Coda) 71and 21114
Pages 1 ar ant of Hea at: If Item:		20a. Method of Disposition 1 △ Burial 2 □ Cramation 3 □ F 4 □ Donation 5 □ Other (Specify)	20b. Pi	lace of Disposition o	on (Nama of ory or othar plac	ce)	Data	20c. Location -	City or Town, Stata
Departm Departm Importar any injur		21. Signature of Funoral Service Ligans	1101	Rob	ert E.	ery March ss of Facility Evans Fur apolis Rd.	neral H	ome, Inc	
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ha death certifi the attending thed for use as	Physician/M	Part II. Other significant conditions cor	tributing to death but not rasu	iting in the unde	riving causa giv	an In Part f.	23b. Dld	tobacco use co	ntribute to the cause of death?
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aw requir	Completed	Chronic Si	noking				24a. Was perfo	an autopsy ormad?	24b. Wara autopsy findings available prior to completion of cause of death?
			•				10	(1 ☐ Yas 2 ☐ No
Physician: this certific	To Be	25. Was casa referred to medical exeminar? 1 Yas 2 No	ospital:	ER/Outpatient	3□ DOA Oth	26. Piaca of Daath ar: 4□ Nursing Hor		ona) dance 8 □Oth	er (Specify)
De de la		27. Manner of Death ↑ Netural 5 □ Pending 2 □ Accidant invastigation	1	28b. Time of Injury	28c. Injun Work			how injury occur	
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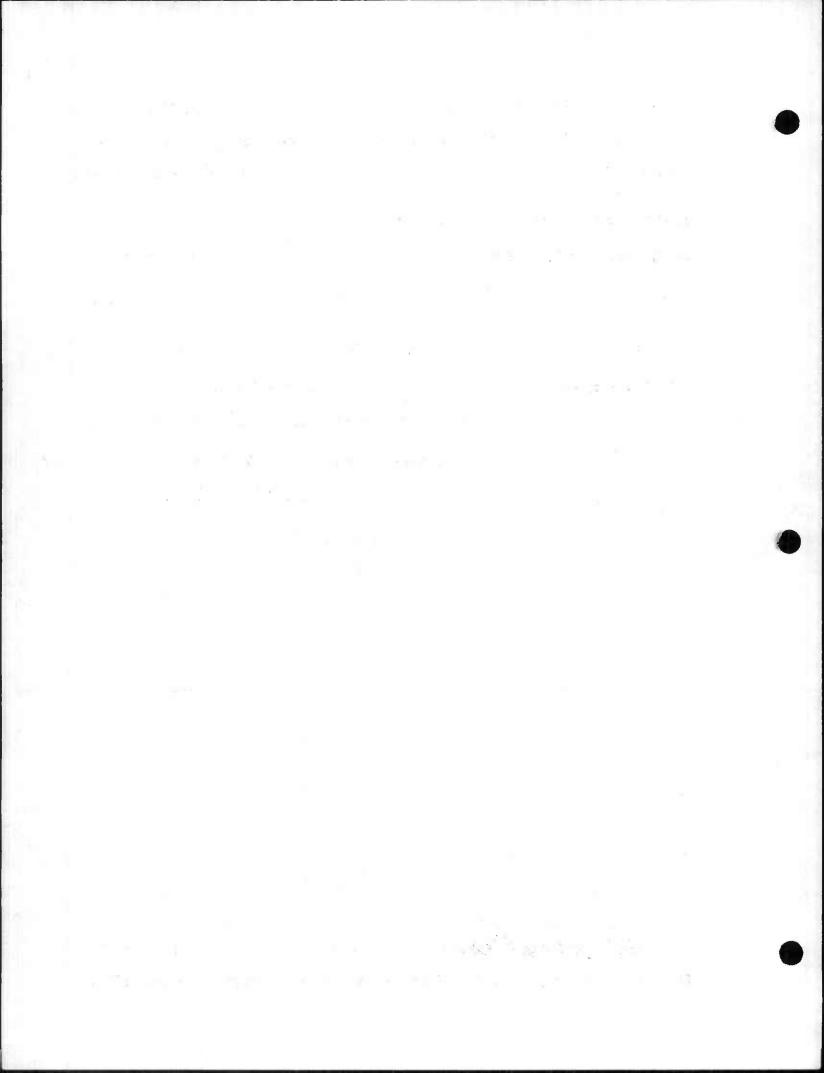
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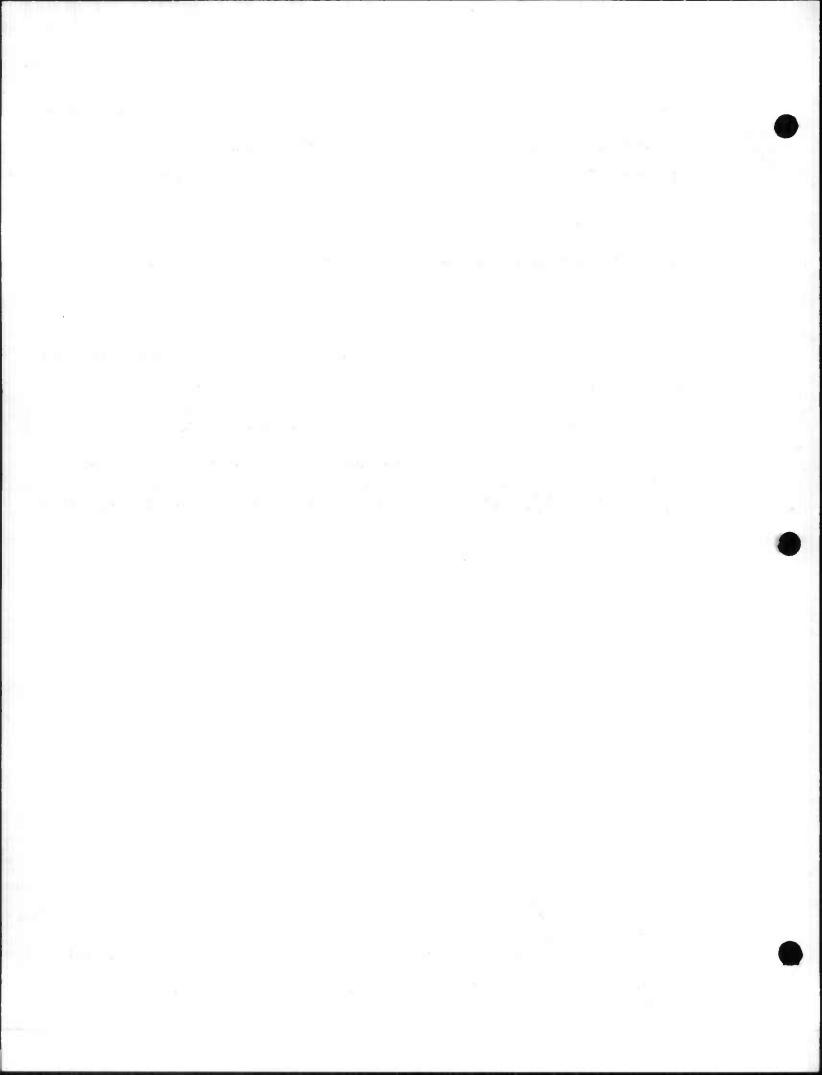
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or 28 De not	Director	10e. Street end Num					10f. Zip Code			10g. Cit	lizen of Whe	Country?
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and Montal and Montal and Montal a marked o	20	Charles F	ischer					Louisa	Sophia	C100	S	
d 2 should h and Mo 7 is marks traumatic		19e. Informent's Nar		Type, Print)				end Number or Ru				
C Heat C Heat Other		Joan P. N 20e. Method of Dispo	osition		20b.	Pleca of Disposition		Place #326	, ROCKV11		-	20852 or Town, Stete
Page national			Cremetion 3 ☐ Other (Specify	Removel from State		hesapeake			3 -3-97	Belt	sville	, Maryland
permit. Pages 1 and 2 Department of Health a Important: If them 27 is any injury or other tra SRIGE.		21. Signeture of Fun	erel Service Licens	Do Do		22. N Ran	n Fune	ess of Fecility	ces. P.	Α.		yland 20910
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ha law requires that has been signe	Completed								24e. Wes	en euto ormed?	psy 24	b. Were eutopsy findings evelleble prior to completion of cause of death?
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Attending Phys or death. ector: After this by the funeral di	ation: To	27. Menner of Deeth 1 Neturel 2 Accident	5 Pending investigation	1 ☐ Inpatie 28e. Dete of Inju (Month, De	iry	28b. Time of Injury	28c. Inju	4 CU Nuising IT	ome 5 ☐ Res 28d. Describe			Specify)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Sulcide 4 ☐ Homlcide	6 ☐ Could not be determined	28e. Pleca of Inj building, et	ury - At h c. (Specil	ome, ferm, street, (y)	fectory, offica		28f. Location (City or To	Street er wn, Stete	nd Number of	Rural Route Number,
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State of Maryland / Department of Health and Mental Hygiene

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					Certi	ficate o	f Death	F	Reg. No.)	00	342
Physic	ian	Decedant's Name (First, Middle	, Last)					Deta of Dea Month	th Dev	Yeer	3. Time	of Death
/Medi		Catherine	М.		Napo	oli		2	28	97	7:	55AM
Exami		4a. Fecility Neme (If not institution	, giva street and number)				4b. City, Town, or	Location of Death	4c. County	of Death		
	, .	Layhill Nursin	g Home				Silver Sp	oring	Mont	gomen	-y	
Funerai		5. Sociel Sacurity Number	6. Sax 7. Ag	je (In yrs. les	N	f Under 1 Year lonths Day	If Under 24 Hr	s. 8. Data of Birth	, Yeer)	9. Birthpi	lece (Stete	te or Foreign
Director		579-14-3835		98	Yrs.			Jan. 13	, 1899		York	
2		Usual Residance of Decedent 10a. State 10b. County		10c City 7	own or Locati	ion				Tag	Od Incide	City Limits
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the Maryland 28a-f show sofffied at	Director	Maryland Monte 10e. Street and Number	omery	S	ilver							
W 9 9		Too. Street and Number				10f. Zip Code			log. Citizen of	what Coun	try?	
a 23	era	15101 Interlache	n Drive Apt	.714	40.111		906		U.S.A			
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hours after tural", or its at Examina	by F	3 Widowed 4 Divorced	ed 1 ☐ Yes 2 ☑ If Yas, Give Year or Detes:	NO	1 🗆	Yes 2√N	o Specify:		Specif			
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be filed with tal Hygiene. d other than event, the M	BeC	17. Father's Neme (First, Middle, L	.ast)	120	ссерет	OHILDE	18. Mother's Ne	me (First, Middle,			ermi	TEIL
	To B	Ignatius Amat	0				Rose	e DeCri	etina			
d 2 should be filled within 72 hours at th and Mental Hygisne. The marked other than "natural", or traumatic event, the Medical Exam	-	19e. Informant's Neme/Relationsh			19b. Mailing A	ddress (Stre	et end Number or R			Stete, Zip	Code)	
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of Head		20a. Method of Disposition	-	20b. Plac	e of Disposition	on (Neme of	-		20c. Location	City or To	wn, State	
0 0		1 ☑ Buriel 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (Sp										
Semit. Par Separtment mportant: any injury once.		21. Signature of Funeral Service L		St.	Mary's	Cemet	ery rass of Facility	3/03/97	Washing	ton,	D.C.	
Dep firmp gany gany		11.	200	1.1	1 Fra	ncis J	. Collins					
-	Н	23a. Pert1. Entar the diseasa, or	18) Cam	psu	500	Unive	rsity Bly	7d.,W.,Si	lver Sp	ring,	MD 2	0901
		shock, or heart failure. List of	only one cause on each li	na.	Jo noi anter ii	ia mode or o	ying, such es cardia	ic or respiratory arr	ası,		Approxim Interval B Onset an	Between
Physician /Medical		immediate Cause (Finel									Onsor an	G Destin
Examiner		disease or condition resulting in death)	e. Artero	sclero	tic Ca	rdiova	scular Di	Isease			Year	S
	ē			Due to (or as	e consequer	ice of):						
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exect n end iel-tre	Exa	Sequentially list conditions, if eny, leeding to immediate		Due to (or as	a consequer	ice of):						
death certificate be executed e ettending physician end ad for use es the buriel-transit		ceuse. Enter Underlying Cause (Diseese or injury that initiated events	C	Due to fee as	10							
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ding lh. After funer	tior	1 X Naturel 5 Pending investigation	(Month, De	y Year)	Injury	28c. inj W	ork? ⊒Yes 2 ⊒No	200. 20000	on injury occur			
i or Attending efter deeth. Director: After d in by the fune	ertification:	3 Suicide 6 Could no	ot be	urv - At home				28f. Location (S	treet end Numt	per or Rura	Route No	um <i>ber</i> .
10年10日	ert	4 Homicide determine	building, et	c. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.aoioty, oo		City or Town				
To the Hospital within 24 hours To the Funeral C	O	29a. Certifier 1 Certifying	Physician: To the best of	of my knowle	dge, death oc	curred at the	time, date and place	e, and due to the o	euse(s) and me	anner ac et	ated	
Fur etely	edicai	(Check only 2 Medical E	xeminer: On the basis of and manner sta	examination	end/or invest	igation, In my	opinion, death occ	urred et the time, d	ete end place,	end due to	the cause	ð(s)
within 2 To the complet	Me	29b. Signature and title of certifier	//			29c. Lica	nsa numbar	2	9d. Date signe	d (Month, L	Dey, Yeer)
F S F O		KL Y	410	(1							
	-	my many	/ vuin	im		D 08	381	F	ebruary	_28,_	1997	
.1		30. Name and address of person V				,						
4		Benjamin Avruni	n, M.D. 1	8111 P	rince	Philip	Drive C	lney,Mar	yland 2	0832		
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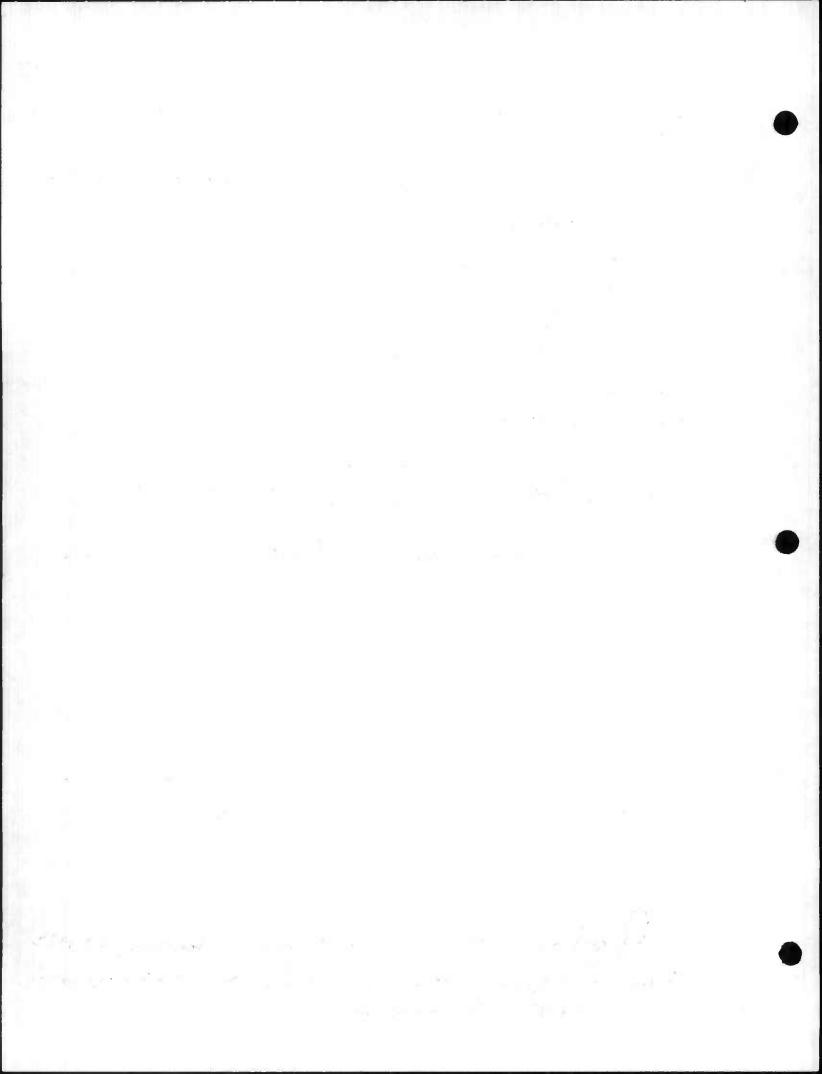
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Physicia /Medic Examin		01 1							2. Dete of D	Dey	Yeer	3. Time of Deeth
Evamin	al	Charles	J	Napi					Febru		1997	5:30 A
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unerai irector		5. Sociel Security Number 235-64-7285		x XM 2□F	7. Age (In yrs	. lest birthdey) Yrs.	If Under 1 Yea Months Deys	If Under 24 H	n. (Month, L	irth Dey, Yeer)	9. Birthpled Country	ce (State or Fore
		Usuel Residence of Deceding 10e. State 10b.	lent County		100.0	ity, Town or Lo	cetion		riugusi	20,134		
f sho	5	247	ntgome	3437			cation				100	I. Inside City Lim 1 ☐ Yes 2 ☑ I
notific notific	Director	10e. Street end Number	negome	ГУ	01r	iey	10f. Zip Code			10a. Citizen a	f Whet Country	
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dical Ex	Completed	15. D	ecedent's Ed	ucation fe completed)		16a. Deced	tent's Usuei Occu	pation	an els in en	16b. Kind of	Business/Indus	stry
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matt	2	Harold Char 19a. Informent's Neme/Re		•		19b. Meilir	ng Address (Street	tend Number or			n. Stete Zin C	ode)
er trau		Patricia E.						ntal Cou			20832	- 30/
E de		20a. Method of Disposition				Piece of Dispo	sition (Neme of netory or other pla		Dete	T	- City or Town	n, Stete
ury or		1 ☐ Burial 2 ②Cren 4 ☐ Donetion 5 ☐ O			late		itan Cre		3/1/97	Alexan	dria,	VA
any injury or a		21. Signature of Funerei S	ervice Licens	م		Fr	Neme end Addrancis J.		Funera	1 Home,	Inc.	20901
sician edicai miner	Jer	Immediate Cause (Final disease or condition resulting in deeth)		. Esa	Phase Due to	es e conseq	CMC uence of):	Amon.			a	mon N
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	by Physician/M	Pert II. Other significant c	onditions co	ntributing to dea	th but not res	ulting in the ur	derlying cause g	ven in Pert I.		tobacco uae c Yes 2□ No		ne cause of death
ge 2 should t	Completed									s en eutopsy formed?	evaile	autopsy findings able prior to eletion of cause eth?
rector, page										Yes No	1 🗆 Y	es No
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of fun	atio		Pending nvestigetion	(Month,	Dey Year)	Injury		rk?]Yes 2□No				
od in by the funeral ed in by the funeral Certification:										(Street end Num own, Stete)	nber or Rural R	Route Number,
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Registrar

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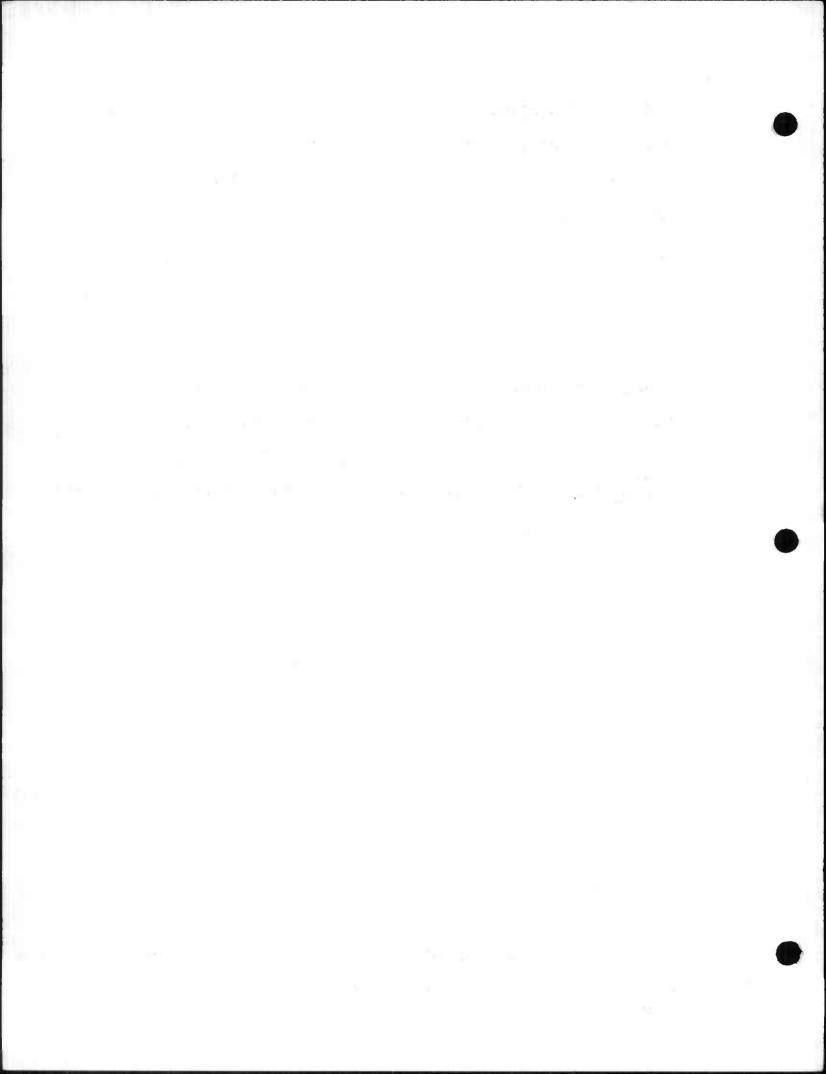
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State of Maryland / Department of Health and Mental Hygiene Q 7

ment of Health and Mental Hygiene 97 08344

						Certifica	te of	Death	7		Reg. No.	, ,	000	44
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+	Funeral				ge (In yrs. last birt		er 1 Year	Elkt If Under		. Date of Bir	Ceci		iace (State o	r Foreign
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	land m		10a. Stete 10b. County		10c. City, Town	or Location						1	0d. Inside Cit	ty Limits
	Meny Hash	ō	MD. Cec:	il	Warw.	ick							1X Yes	2 No
	r 28a-f show	Je C	10e. Streef and Number			10f. 2	ip Code				10g. Citizen of \	What Cour	ntry?	
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020	72 hours after death with the Meryland natural', or itema 23a or 28a-f show dical Examiner must be notified at	by Funeral Director	1 ☐ Never Married 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces	? I No	If Yes, sp	ecify Cub	an, Mexica	in, Puerto Ri	can, etc.)	Bled	ck, White,	efc.	
9	72 hours natural', dical Ex		15. Decedent's			Decedent's Us	ual Occu	petion			16b. Kind of B	usiness/inc	dustry	
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<u>8</u>	han han heur		Alleria de la constanti de la								er, City or Town,		Code)	
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Baltlmore,	permit. Peges 1 and 2 should be filed w Department of Heelth and Mental Hygies Important: If Item 27 is marked other the any Inlury or other traumatic event, man		20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetion 3 4 ☐ Donetlon 5 ☐ Other (Special Contents)		comotor	Disposition (N y, cremetory or end Ce	other pla	,	3/1	2/97	20c. Location -		- '	
alt	Departs Departs Imports any ink		21. Signature of Funerel Service Lic	ensee	continue una			ess of Facili						
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			23e. Parti Enter the disease, or co shock, or Heert failure. List on	mplications that cause	ed the death. Do n	Box 2	3.5 de	Galer	na, M	D. 21	635		Approximate	
1	AC 1033		shock, or Heart failure. List on	y one cause on each	line.	or or to the thi	ad or dy	ng, such es	o cardiac or i	espiratory e	1031,	1	Interval Bety Onset and D	ween
	Physician /Medical		fmmedleta Cause (Finel	0	1		,							
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of	After this funeral di	. To	27. Menner of Death	1 ☐ Inpat			WA	4 🗆 141	1		dance 6 Oth		y)	
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3	Attending or deeth. actor: After by the fune	Ica	2 ☐ Accident investigeti 3 ☐ Suicide 6 ☐ Could not	ha	None At home for			141		f Location /	Otropet a said Mount	har ar Our	I Courte Mumi	har
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	To the Hospital or Attending Phy within 24 hours efter deeth. To the Funeral Director: After thi completely filled in by the funeral	edicai	29e. Certifier (Check only one) 1 Certifying F 2 Medical Exi	thysician: To the best miner: On the basis of end menner s	of examination and	deeth occurre Vor investigation	d at fhe fi n, in my d	me, dete er opinion, des	nd piece, en eth occurred	d due to the at the fime,	ceuse(s) and me dete and place,	and due to	teted. the cause(s))
	To the To the Com	Σ	29b. Signature and title of certifier			2	9c. Licen	se number			29d. Date signe	d (Month,	Day, Year)	
			Wallace 10		lac ~		PO	07/2	9		March	Q /q	97	
	·n	ŀ	30. Nema and address of person who		deeth (Item 23a) (Type, Print\					MALEN	7, 17	1/	
								16.	2-1	219	13			
	Sta	te	31. Dete filad (Month, Day, Year)	BEN 5HF	rer's Signature	ے دہ	201	Ton	ma	p= 1 9	. 0			
	Registr		MAR 1 1 1997	Julia Da	rer's Signature	LIL								



State of Maryland / Department of Health and Montal Hydione

			Decedent's Neme (First, Middle, La	State of Maryla		Certificate of		Re	g. No.	7 08345
	Physic		ELSI	,	RD			2. Dete of Deeti Month FEB • 2	8,1997 ^{Ye}	3. Time of Deeth 4:37 PM
Y	/Medi Exami		4e. Fecility Neme (If not institution, giv				4b. City, Town, or		4c. County of D	
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	Funeral , Director			Sex 7. Age (In yrs	i. last birthe Yr	Months Dave			yeer) , 1902 R	Birthplece (State or Foreign County) HODE ISLAND
	and		Usuei Residence of Decedent 10e. Stete 10b. County	10c C	ity Town	or Location				104 1-14-07-11-7
	ath with the Marylan 23a or 28a-f show	Director	VA. FAIRFA	X	RES	STON				10d. Inside City Limits 1 Yes 2 No
	ath with t	rai Dir	11450 - N. SH	ORE DR.		10f. Zip Code 2 2 0	90	10	U.S.A	
21215-0020	72 hours effer death with the Maryland natural; or items 23a or 28s-f show pical Example: Frest be notified at	by Funeral	11. Marital Status 1□ Never Married 2□ Married X□ Widowed 4□ Divorcad	12. Wes Decadent Ever in I Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes:	U,S.	13. Wes Decedent of If Yes, specify Cult 1 ☐ Yes 2 ☐ Wo		pecify Yes or No- o Rican, etc.)	Bleck, W	merican Indien, /hite, etc. WHITE
15-(in 72 ho	Completed	15. Decedent's Ed (Specify only highest gre	lucation de completed)	10	ecadent's Usuel Occu	during most of wo	rking	6b. Kind of Busine	ss/Industry
12	filed within Hygiene. ther than "ther than "ther than "the	dmo	Elementery/Secondary (0-12)	College (1-4or 5+)	11	fe. DO NOT use retire	ed)		NOT AVA	TLARLE
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/lar	Mental Mental arked o	To B	JOHN HANNUS					DA CARL		
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Baltimore,	Pages 1 nent of He int: If iten iry or oth		20a. Method of Disposition 1 XBuriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify	Removel from State	cemetery,	isposition (Name of cremetory or other ple JUT GROVE			Oc. Location - City ERNDON,	
Balt	permit. Pag Department Important: fi any injury o		21. Signeture of Funerel Service Licen	see -COM-A		22. Name end Addr HYSONG	ess of Fecility CO., INC	NT TAT	WASH D	C
	-		23e. Part1. Enter the disease, are supposed shock, or heart feilure. List only	licute in that caused the dee	th. Do not	enter the mode of dy	ing, such es cardied	or respiretory erre	st,	Approximete Intervel Between
	Physician /Medical		immediate Cause (Final	V1000 6		*	1			Onset end Deeth
1	Examiner		diseese or condition resulting in deeth)	e. IVal	M	NI	(00)			& wells
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/ita	ysician: The is certificate director, pag	Be (25. Wes case referred to medical exeminer?				26. Plece of Dee	th (Check only one)	
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Division of	tending Fleath. for: After the funer	Certification:	27. Menner of Deeth 1 Heturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		28b. Tim İnjui	ry Wo	ry at rk? IYes 2 □ No	28d. Describe how	v injury occurred	
DIV	Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the fune		4 Homicide determined	28e. Pleca of injury - At h building, etc. (Special	ome, ferm, fy)	street, fectory, office		28f. Location (Stre City or Town,	eet end Number or Stete)	Rural Route Number,
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	29e. Certifier (Check only one) 29e. Certifier (Check only one) 29e. Certifier (Check only one) 29e. Signiture and title of certifier 29e. Signiture and title of certifier 29e. License number 29e. Certifier (Check only one) 29e. Certifier (Check only one) 29e. Certifier (Check only one) 29e. Certifier (Check only one) 29e. Certifier (Check only one) 20e. Certifier (Check only one) 20e. Certifier (Check only one) 20e. Certifier (Check only one) 20e. Certifier (Check only one) 20e. Certifier (Check only one) 20e. Certifier (Check only one) 20e. Certifier (Check only one) 20e. Certifier (Check only one) 20e. Medical Examinaer: On the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner as one) 20e. Certifier (Check only one) 20e. Certifier (Check on								
	D D D	2	29b. Signature and title of certifier). Karesh v	5	29c. Licens	1726	m 29	avch /	nth, Dey, Year)
(3/		30. Name end eddress of person who co DR • CHARLES K	ompleted cause of deeth (Iter CARESH- 970)	n 23e) (Tyr L — VI	De, Print) EIRS DR.	ROCKVI	LLE, MD.	20850	
	Sta Registra		31. Dete filed (Month, Dey, Year) MAR 04. 1997	Registrer's Signe		м				
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Physician	_	John B. Owen						Month March	3, 1997	Year 7	5:20 pr
/Medica	_	4e. Facility Neme (If not institution, g	give street end number)				b. City, Town, or				5:20 pi
Examine	1	Prince George's									0010
-	-		The second secon	center a (In yrs. løst bir	abdout Hillada	r 1 Year	Cheverly If Under 24 Hrs.			e Geor	~
uneral irector		578-10-5700 Usual Residence of Decedent	1⊠M 2□F		Yrs. Months		Hours Min.	8. Date of Bi (Month, D April	ay, Yeer) 12, 1910	South	Caroli
show of at		10a. State 10b. County		10c. City, Tow							Insida City Lir
重量	2		George's	Berwyn	n Height						TAS Z
5 8	1	10e. Street end Number			10f. Ziş				10g. Citizen of	What Country?	
23s	8	6220 Seminole H	Place		20	740			U.S.A.		
than "natural", or thems 23s or 28s-f show the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Nevar Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Dacedant Armed Forces? 1 Yes 2 1 Yes, Give Year or Detes:		13. Was Dace If Yes, spe		ispanic Origin? (S in, Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	o- 14. Rad Bie	ce - American I ck, White, etc.	
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	5	8		Bu	ıs Opera	tor			D.C. Tr	cansit	
등 등	Be	17. Fether's Neme (First, Middle, Le	st)				18. Mother's Nar	ne (First, Middle	a, Maiden Sumen	ne)	
	0	John Owen					Susie H	opkins			
BUTA UTA		19a. Informant's Name/Relationship	(Type, Print)	19b	. Mailing Address	s (Street	end Number or Ru	ral Route Numb	ber, City or Town,	, Steta, Zip Cod	de)
tem 27 is merks other traumetic		Mina G. Owen -	Spouse	62	220 Semi	nole	Place,	Berwyn	Heights.	MD 20	740
item 27 other to		20a. Method of Disposition			f Disposition (Natry, crematory or o			Dete	20c. Location		
Y 00'		1 Burial 2 Cremation 3						107/07			
and Control	-	4 Donation 5 Other (Spe		Fort	Lincoln			/07/97	Brentwo	ood, Ma	ryland
Important: if its any injury or o once.		21. Signature of Funerel Servica Lie	- Frank	/		s Ga	sch's So more Ave				20781
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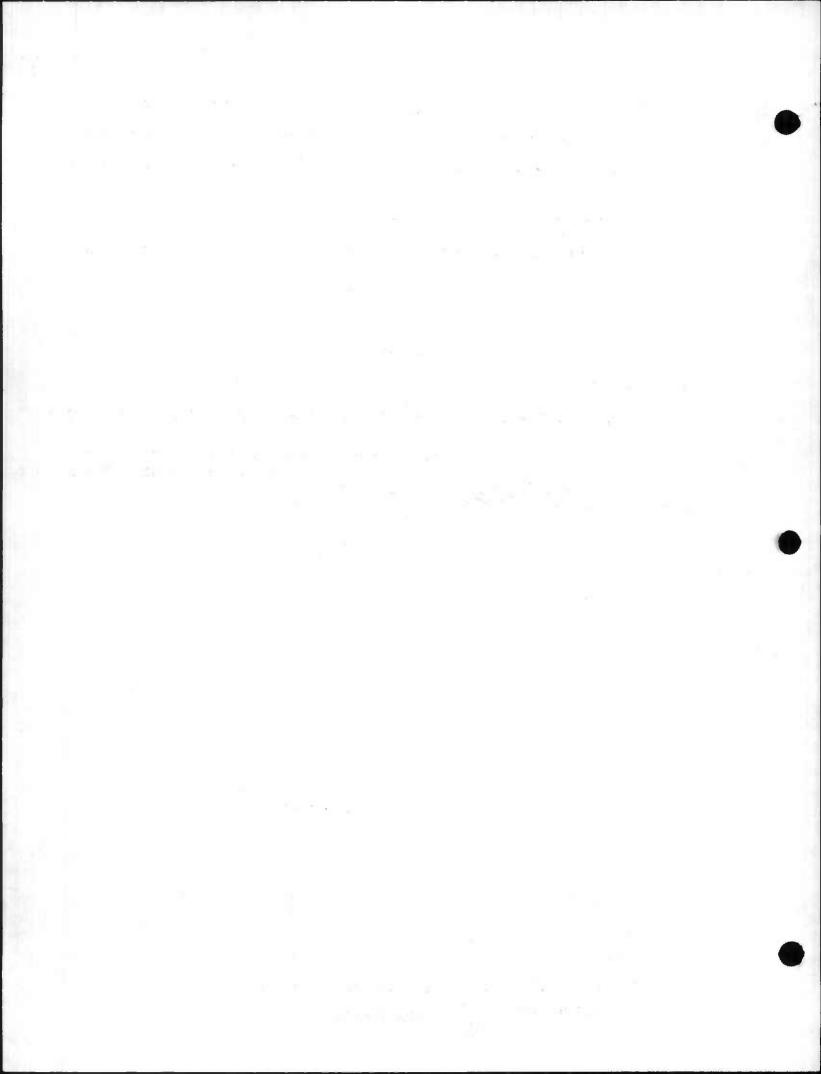
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State of Maryland / Department of Health and Mental Hygiene

08347 Certificate of Death 1. Decedent's Name (First, Middle 1 ast) 2. Date of Death 3. Time of Death MARCH 2, Day 1997 Year **Physician** ADELE 7:59 A.M. WENDER **PESKOWITZ** /Medical 4a. Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner MONTGOMERY OLNEY MONTGOMERY GENERAL HOSPITAL 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 M 2 F 82 Yrs Director 132-05-6044 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Director 1 Yes X No SILVER SPRING MD MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b UNITED STATES 20906 3330 N. LEISURE WORLD BOULEVARD Herris 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Detes: 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 72 hours after 1 Never Married Married WHITE Baltimore, Maryland 21215-0020 ò 1 ☐ Yes 2 No Specify by 3 ☐ Widowed 4 ☐ Divorced 'natural'. i filed within 72 ho i Hygiene. other then "natura wnt, the Medical § Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygion Important: if Item 27 is marked other than any injury or other traumatic event, Ital. 2005. OWN HOME HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Surname) ELKE KESTAIN MEYER WENDER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3330 N. LEISURE WORLD BOULEVARD, SILVER 25966, MD 19a. Informant's Name/Relationship (Type, Print) SAMUEL PESKOWITZ (HUSBAND) 20b. Place of Disposition (Name of cometery, cremetory or other place). NORBECK
3/4/1997 OLNEY, MARYLAND
3/4/1997 OLNEY, MEMORIA 20a. Method of Disposition
1 ☐ Surial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility DANZANSKY GOLDBERG MEMORIALCHAPELS 21. Signetura of Forthral Service Licensee 1170 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852
enter the mode of dying, such as cardiec or respiretory arrest, Part1. Enter the disease, or complications that caused the deeth. Do shock, or heart failure. List only one cause on each line. **Physician** /Medicai Immediate Ceuse (Final disease or condition resulting in deeth) LOUES Examine Due to (or as a consequence of) Examiner Attending Physician: The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) P.O. Box 68760. Physician/Medical Due to (or as a consequence of) use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 | Yee 2 | No 3 | Probably 4 □-Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? page 2 s 1 Yes 2 ₽No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA sint funeral 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Waturai 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: filled in by the 3 Suicide 8 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide Medicai 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 2,1997 1024571 m D em 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 JAY WEINER 11533 TWINING LANE POTOMAC, MARYLAND 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 whia Davidson Registrar

DHMH 16 Rev 6/95



State Registrar

31. Dete filed (Month, Day, Year) MAR 0 3 1997

George

29b. Signetura and title of certifier

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A. Sotas

30. Neme and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

9707

MEDICAl Center Dn #300 Rocky. 1/2 MD 20850 32. Registrer's Signeture ulia Davidson

29c. License number

29d. Date signed (Month, Day, Year)

P.O. Box 68760,

of Vital Records,

Division

State of Maryland / Department of Health and Mental Hygiene 08349 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Physician Month Yeer ITSENBERGER HUGUSTA 1997 MARCH /Medicai 4e. Fecility Name (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Takoma Park Montgomery Washington Adventist Hospital 7. Age (In yrs. last birthdey) | If Undar 1 Yaar | If Undar 24 Hrs. | Months | Deys | Hours | Min. 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year)
October 20, 1908 W. Virginia 6. Sex **Funeral** 1 □ M 2 → F Hours 232-48-3360 88 Yrs Director Usuel Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location the Marylar 10d. Insida City Limits than "natural", or items 23e or 28e-f show the Medical Examiner must be notified at Silver Spring 1 ☐ Yes 2\0\0 Directo Maryland Montgomery 10e. Street and Numbar 10f. Zip Code 10g. Citizen of Whet Country? 20905 United States 2113 Sondra Court "natural", or items 23a Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 11. Maritel Status Was Dacedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Ricen, atc.) 14. Race - Amaricen Indien, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White by 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hyglane. College (1-4or 5+) Elementery/Secondery (0-12) Registered Nurse Medical poemit. Pages 1 and 2 should be filled with Department of Health and Mental Hyglen important; if Nem 27 is marked other the any Injury or other treasments. 17. Fether's Neme (First, Middle, Lest) 18. Mother's Neme (First, Middla, Melden Surneme) Be Harless Theodoscia Stone James 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 2113 Sondra Court, Silver Spring, Maryland 20905 Patricia Prins 20e. Method of Disposition 20b. Piece of Disposition (Neme of cematary, cremetory or other pleca) 20c. Location - City or Town, Stata 1 Buriel 2 ☐ Cramation 3 ☐ Removal from State 3-6-97 Beckley, WV 4 ☐ Donetion 5 ☐ Other (Special) Blue Ridge Cemetery 22 Neme and Address of Fecility
Hines-Rinaldi Funeral Home, Inc. 11800 New
Hampshire Ave., Silver Spring, Md. 20904 21. Signature of Funeral Service Licensee 23e. Pert1. Enter the disease, or complications that consed the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or hear feiture. List only one cause on each line. **Physician** /Medical Immediete Ceuse (Finel Preumonia disaesa or condition resulting In deeth) 2 Weeks **Examiner** Due to (or es a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in daath) Last and burial-tran Due to (or es a consequenca of): Records, P.O. Box 68760. physiclan Physician/Medicai the Due to (or as a consequence of): Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributs to the cause of death? as been signed by the 2 should be detach Obstructive Polmonary Disease 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were eutopsy findings eveilabla prior to completion of causa of death? 24e. Wes en eutopsy performed? Asthmetic Bronchitis Diabetes Mellitus 2 No 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

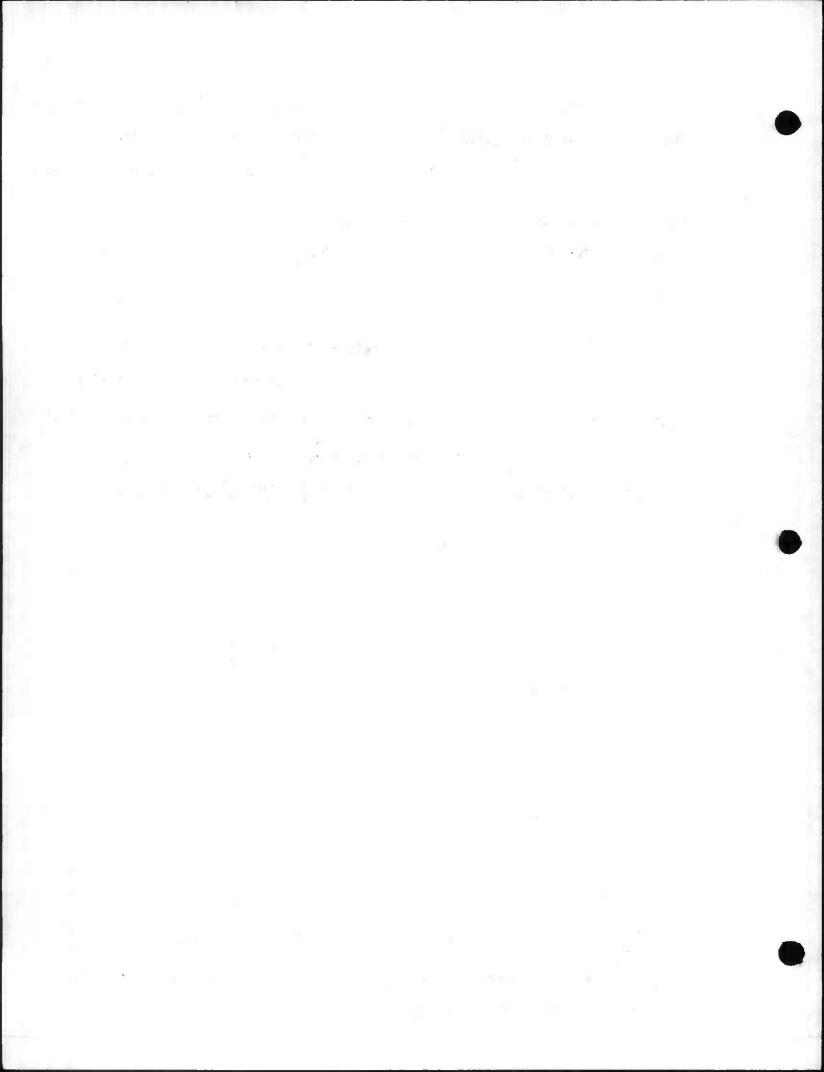
To the Funeral Director: After this certific completely filled in by the funeral director, 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 ☐ Yes 2 No 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. injury et Work? 1 Neturei 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Sulcida 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 28a. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide Medicai 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end pieca, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) end manner steted. (Check only one) 29b. Signatura and title of certifiar 29c. Licansa number 29d. Data signed (Month, Dey, Year) March, 3, 1997 D12582 M.D. 6 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Alfred 7603 Carroll Avenue Takoma Park, MD 20912 Munzer M.D. 32. Registrer's Signeture 31. Dete filed (Month, Dey, Yeer) State

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Registrar

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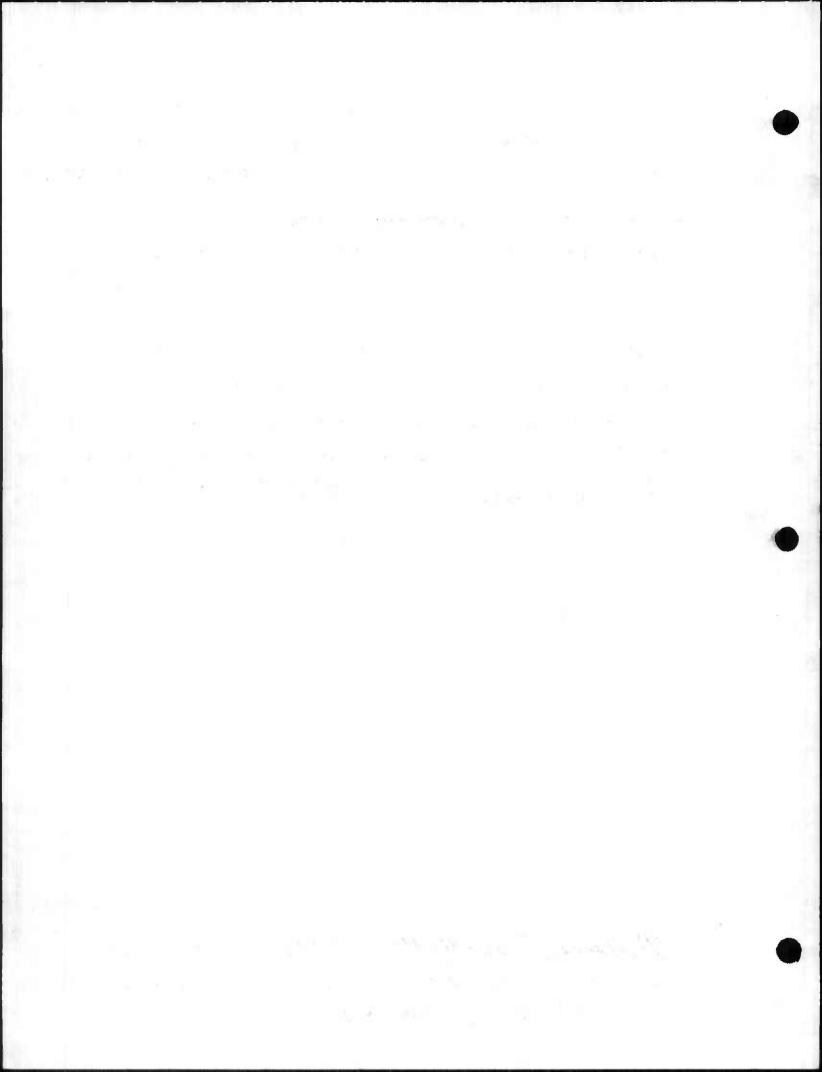


State of Maryland / Department of Health and Mental Hygiene

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within 24 hours aftar deaf To the Funeral Director: completely filled in by the	edical C	29a. Cartifier (Check only one) 2 Medical	ng Physician: To the Examiner: On that end mar	e bast of my knows as is of axamin	owledge, deet ation and/or In	h occurred vastigation	at the ti	ma, data and opinion, daat	d placa, h occurr	and due to red at tha th	tha caus	sa(s) end me and place, e	nnar es st end dua to	ated. tha cause(s)
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Sta Registr		31. Dete filed (Month, Day, Year,	0 3 1997	Registrar's Sign	atura									
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DHMH 16 Rsv 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08351 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** 1997 HAZEL M. PRICE MARCH 9 10:20 AM /Medical 4a. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Daeth Examiner WALDORF HEALTH CARE CENTER WALDORF CHARLES If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthdey) If Undar 24 Hrs. 8. Dete of Birth (Month, Dey, OCT 12 9. Birthplace (State or Foraign Country) West Virginia Days 10 M 20 F Min. Monfhs Hours 280-26-5733 71 Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Charles 1 Yas 2 □ No Waldorf 10s. Street end Number Waldorf Health Care Center 10f. Zip Code 10g. Citizen of What Country? 4140 Old Washington Road 20601 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status 14. Race - American Indian, Bleck, White, atc. 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Yes 2 No þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Waitress 8 Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumama) Be J. Benjamin Thomasson Ida M. Thomasson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) 1713 Temi Drive Waldorf, MD 20601 Nancy Kuty (Niece) 20b. Place of Disposition (Neme of cemetery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Denation 5 Other (Specify) Metropolitan Crematory 3+14-97 Alexandria, VA 21. Signature of Wylce Licensee 22. Nama and Addrass of Facility J.H. Eberwein Mortuary M00173 4433 White Plains La White Pls., MD 20695 ven at 1. En er the diseast or complications that caused the daath. Do not antar tha moda of dylng, such es cardlac or respiretory arrest, shock, or heert failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Cause (Finel with metastasis disease or condition resulting in death) arcinoma 3 4Rs Due to (or es a consequenca of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Lasf Due to (or as e consequence of): Physician/Medical Due to (or as e consequenca of) Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 □ Unknown Completed by 24b. Wera autopsy findings available prior to complation of cause of death? 24a. Was en eutopsy performed? 1 Tes 3/EXNO 1 Yes 2 No Be 25. Was case referred to medical 26. Placa of Deeth (Check only one) examiner? Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 1 ☐ Inpatiant 2 ☐ ER/Outpetlent 3 ☐ DOA 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) edical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 2 ☐ Accident 5 Pending investigation 1 ☐ Yas 2 ☐ No 6 Could not be detarmined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier

/Medical **Examiner** The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. or Attending Physician: deeth after deeth within 24 hours a
To the Funeral C

physicien end the burial-tran USB 88 ettending | ate has been signed by the page 2 should be deteched certificate has this funeral Affer 2

Funeral

Director

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Peges 1 and 2 should be 9 nent of Health end Mental I int: If Itam 27 Is marked of

permit. Peges 1 and 2: Department of Health or Important: If Itam 27 Is any Injury or other treughts.

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filed within 72 hours after

21215-0020

Baltimore, Maryland

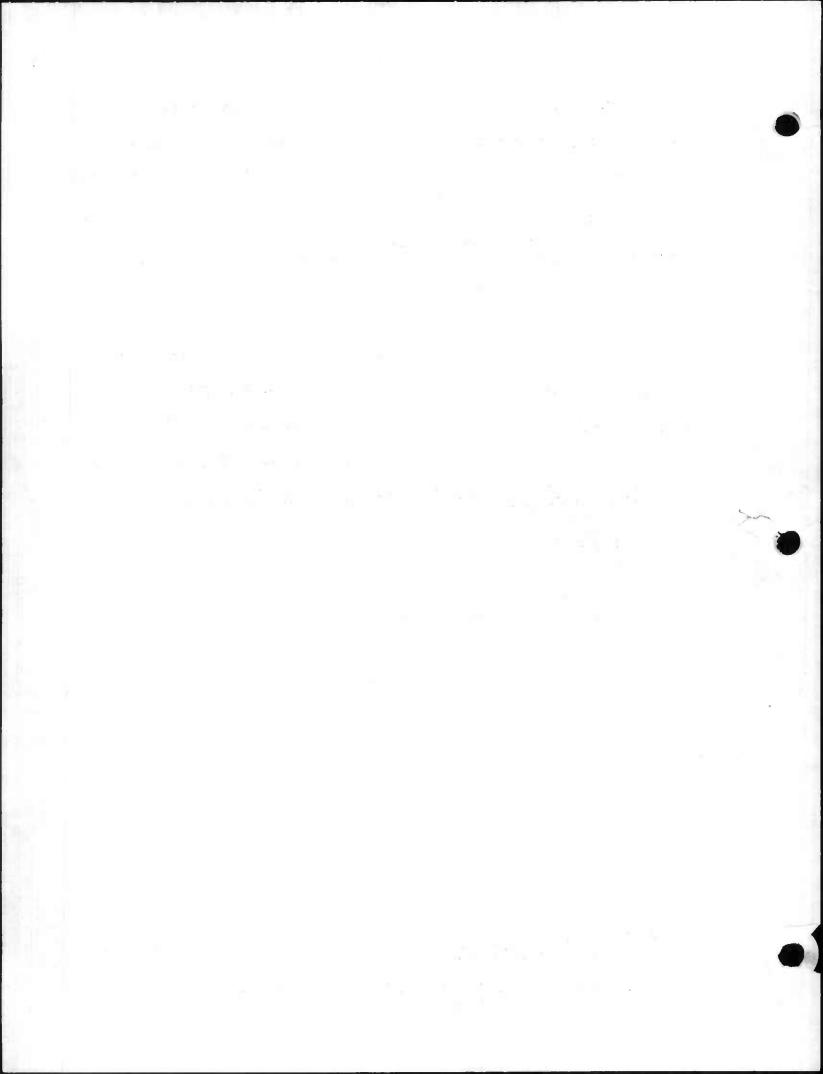
12 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, date and pleca, end due to the cause(s) end menner as stated. (Check only 2 Medical Examiner: On the basis of axamination end/or investigetion, in my opinion, death occurred et tha fima, date end piece, and dua to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) D15513 March 10, 1997

30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)

2 St Patricks Dr #502 Waldorf, MD 20603 Lucio S. Villa-Real MD

31. Dete filed (Month, Dey, Year) State MAR 11 Registrar

32. Registrar's Signeture Randall

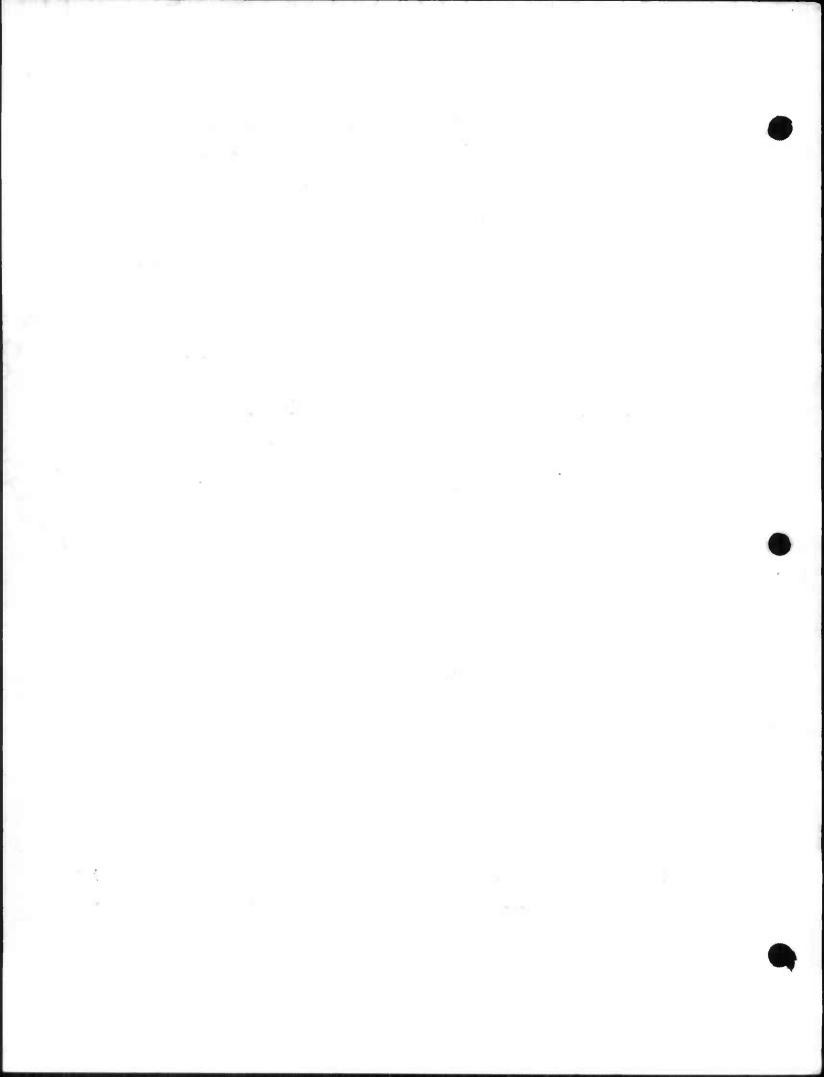


TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	0 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should	2 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	if them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING	TO THE FUNERAL DIRECTOR: After	be filed within 72 hours after death with	IMPORTANT: If Item 28 Is marked

32. REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day, Year)
MAR 1 1 1997

	FOR STATE REGISTRAR	STATE OF I			TMENT				MENTAL HYGIEN		9 /	08352
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH			3. TIME OF DEATN
	Jane		Elinor		P	oynt	on		March 8,1	997	PASY	7:30PM M
7	4. SOCIAL SECURITY NUMBER 216-14-8886	5. SEX	6. AGE (In yrs. lest	birthday) YRS.	IF UNDER	DAYS	IF UNDER	MIN.	7. DATE OF BIRTH	921	Countr	PLACE (State or Foreign
œ	9a. FACILITY NAME (If not institution, give str Sacred Heart H						R LOCATI		EATH	9c. COL Prin	UNTY OF D	
5	RESIDENCE OF DECEDENT	10000										
DIRECTOR	Maryland Princ	e George	e's		y, town of eenb		ION					10d. INSIDE CITY LIMITS? 1 YES 2 NO
AL	10e. STREET AND NUMBER					101	ZIP COD	E		10g. Cf1	TIZEN OF V	VNAT COUNTRY?
EH	8150 Lakecrest	Drive A	pt 308			-	2	20770)	U	S.A.	
BY FUNERAL	11. MARITAL STATUS 1 XNever Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDEN	T EVER IN U.S. ARI	MED IO		f yes, sp		n, Mexica	NIC ORIGIN? (Specify Ya n, Puerto Rican, atc.)	e or No—	Black	E — American Indian, k, White, etc.
	15. DECEDENT'S EDUC		16a. DE	CEDENT'S	USUAL O	CCUPATIO	ON		16b. KIND OF BU	SINESS/IN		
E	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5	life	ve kind of Do NOT u	work done (se retired.)	during mo	st of worki	ng				
AP.	12th	N/A		ative	Eng	rave	er		U.S	. Gov	vernm	ent
COMPLETED	17. FATHER'S NAME (First, Middle, Last)							NER'S NA	ME (First, Middle, Maider	Surname)		
BE (Francis Bac	on F	ovnton					Eva	Mari		Gra	
TO B	196. INFORMANT'S NAME (Type/Print) Mary W. Goodinan	(Siste	er) 8	MAILING 3150	Lake	Cres	nd Number St Dr	or Rural	Houte Number, City or Tox ot. 308 Gr	vn, State, Z eenbe	elt,	MD 20770
	20s. METHOD OF DISPOSITION 1X Burlel 2 Cremation 3 Remarks 4 Donation 5 Other (Specify)	ovel from State	20b. PLACE A cemetery, cre-	matory or q	ther place)	emet	erv	/arch	111, Su	itla	nd, M	larvland
	21. SIGNATURE GRIPUNERAL SERVINE LIG	fal	/		22.	NAME A	AD ADDRE	SS OFTA	Lee F andria Fer			
	23. PATT L Enter the diseases, or c abock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death)	omplications the	use on eech line	•				ing, suc	h as cardiac of loss	iratory a	rrest,	Approximata Interval Between Onset and Death OAYS
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST	DUE TO	OR AS A CONSECUTION OF AS	RE_ DUENCE O	F):							Zweeks
PHYSICIAN: MEDICAL	PART II. Other algorificant condition Conserve Left henin DID TOBACCO USE CONTR	heart -	fa, lure						1 TYES	RMED?	246	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
N	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	144	26. PLAC	E OF DEA	TN (Check							
SIC	1 VES 2 NO	HOSPITAL:	ER/Outpatient 3	□ DOA	4 Nur		n 5 🗆 R	asidenca	8 Other (Specify)			
ВУ РН	27. MANNER O DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE Of (Month, i		28b. TIN	ME OF JURY M	28c. INJ WC	PRK7	□ NO	28d. DESCRIBE NOW	INJURY O	CCURED	
ED	3 Suicide 8 Could not be determined	28s. PLACE (building	OF INJURY — At ho , atc. (Specify)	me, term,	atreet, fact	tory, affic	•		281. LOCATION (Street City or Town, State		er or Rural i	Route Number,
COMPLET	nee)								to the cause(s) and m			
00	2 MEDICAL EXAMINE		xemination and/or	Investigati	on, in my o	opinion, c	leath occu	red at the	time, data and placa, a	nd due to	the cause(s) and manner as stated.
BE	206 EIGHADHRE AND TITLE OF CENTINE	tu	2				29c. LIC	ENSE NU	MBER 'SO		3/10	(Month, Day, Year)
0	30. NAME AND ADDRESS OF PERSON WAR	o completed call	7500 Gree	m 27) (Type enway	y Cer	ter	Driv	ve S	uite 430 G	reen	belt	MD.



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

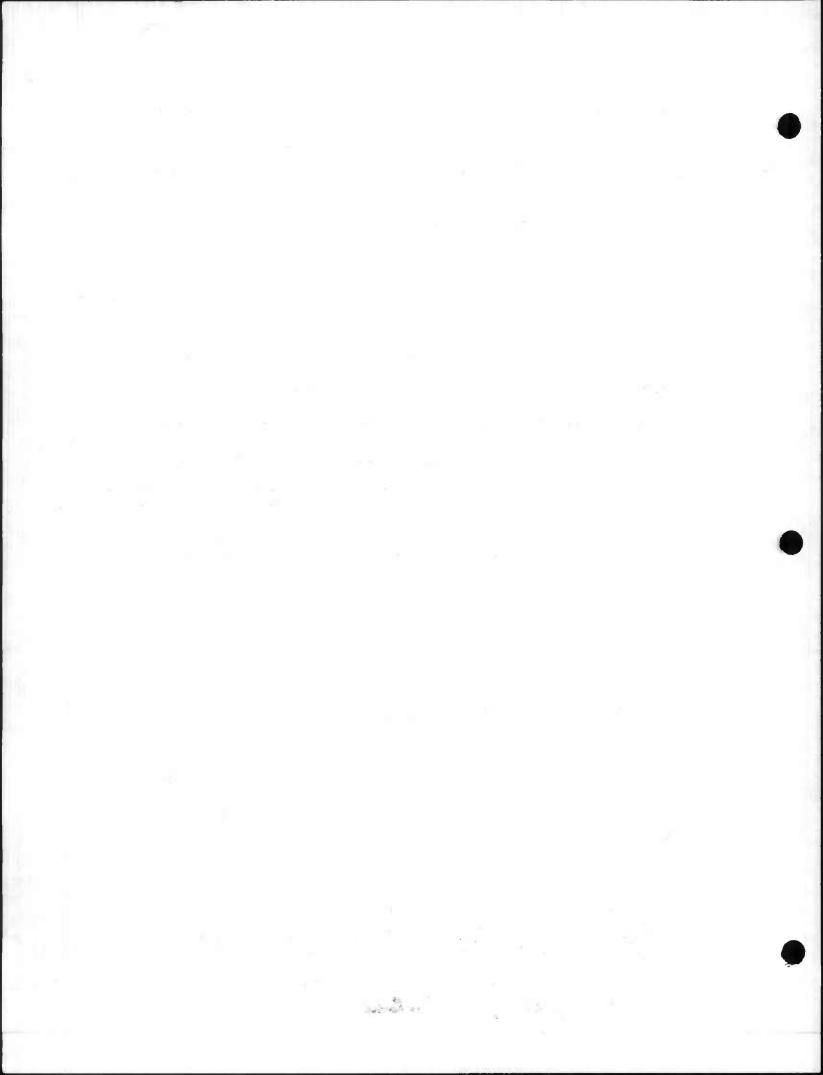
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			1. Decedent's Nam	ne (First, Midd	fle, Last)			001	incate c	-	Joann		2. Date of D		T	3. Time of Death
	Physic /Medi			ELIZA	BETH	Α.	PRE	ESIDE	NT				Month	Day 28	97	12:078
	Exami		4a. Facility Name ((If not institution	on, give street a					4	b. City, To	wn, or Lo	ocation of Dea		inty of Death	and of the
			SOUTHER	N MAR	YLAND	HOSP	ITAL				Clin	ton		P.	G.	
	Funeral		5. Social Security I		6. Sax	X	e (In yrs. la:		If Under 1 Ya Months Da		If Undar Hours	24 Hrs. Min.	8. Date of B	irth ay, Year)	9. Birth	piaca (Stata or Foraigi ntry)
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	with the Maryla a or 28a-f show the notified at	ire	10e. Street and Nu	mbar					10f. Zip Cod	le				10g. Citizen	of What Cou	niry?
	23 w	ral	8326 Wo	odyar	d Rd.				2073	35				U.	S.A.	
	Nems Nems	Funeral Director	11. Marital Status	V	Arm	s Decadent I ned Forces?		13. V	Vas Decedent of Yes, specify C	of Hi	spanic Ori n, Mexicar	gin? (Spi	ecify Yes or N Rican, atc.)	0- 14. [Raca - Ameri Black, White,	can Indian, atc.
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lan,	and the		19a. Informant's N			nt)		19b. Mailin	g Address (Stre	eet a	ind Numbe	er or Rura	a/Route Num	ber, City or To	wn, State, Zij	o Code)
	and sellh her tr		Alex Pr		nt				Woody	`	rd R	d.C.	linto	n,Md.2	0735	
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,	h certificate be executed ending physician and r use es tha bunel-trensit	Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Diseasa or	nditions, nmediate	b		Due to (or a	s a consequ	uence of):							
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89	ng ph	an/Medical	resulting in death) I	Last												
×	th ce	lan			d										1	
0	the el	Physici	Part ff. Other signif	icant condition	ons contributing	to death bu	ut not resuiti	ng in the un	derlying cause	give	n in Part i.		23b. Dfd	tobacco use	contribute to	the cause of death?
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00	shour	Completed												ormed?	av	ailable prior to
Be	The law ate hes b page 2 si	omp											10	Yes 2 XXX		death? □Yes 2□No
		BeC	25. Was case refer	red to medica							26. Place	of Death	(Check only		16	148 2 NO
>	0 0	To	examiner? 1 ☐ Yas 2∰	No	Hospital:	1 inpatier	nt 2 NEF	VOutpatient	3□ DOA	Othe	P*			idenca 6 □0	Othar (Specif	(v)
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sio	Attending in death.	cati	2 ☐ Accident 3 ☐ Suicide	investig	gation						es 2□ñ	No				
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_	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only	1☑ Certifyin	g Physician: T Examiner: On	o the best of	f my knowle	dge, death	occurred at the	time	e, date and	d placa, a	and due to the	cause(s) and	mannar as s	tated.
	the the mplet		Olio)		ano	manner stat	ted.	and or mive				ii occuire	o at the time,			
	5 ¥ 5 000		29b. Signature and	title of cartifie	0				29c. Lica					29d. Data sig	nad (Month,	Day, Year)
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(6/		30. Name and addre Keit		who completed rton M					ıd	Hos	pita	al Cli	nton,	MD.	
	Sta Registra	re-	31. Date filed (Mont			32 Registra					711					

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Physician		 Decedent's Name (First) 	, Middle, Li	ast)					1	2. Dete of De	Reg. No.	-0.	3. Time of I
/Medical	_		MAT	TTIE	Pu	ILLE	7			Month FEBUR	Dey 28	Yeer 1977	
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uneral rector		5. Sociei Security Number 239-24-1045 Usuai Residence of Deced		Sex 7. 1□M 2 X 1F	. Age (In yrs.	lest birthday) Yrs.	If Under 1 Yee Months Deys		Min.	8. Dete of Bi Month, D NOV 22	rth ay, Year) 1911	9. Birth	place (State or GINTA
show	- 1-		County		10c. Cit	ty, Town or Lo	ocation						10d. Inside City
be notified at			INCE	GEORGE	CL	INTON							1X Yes
ral Dire		10e. Street end Number 6004 CLOVER	LEAF	AVENUE			10f. Zip Code 2073	35			U. S.		untry?
Examiner must	2	11. Maritel Stetus 1 □ Never Married 2[3 Widowed 4 □ Div		12. Was Decede Armed Force 1 Yes 24 if Yes, Give Yeer or Dete	No No		Wes Decedent of If Yes, specify Cul 1☐ Yes 2☐ X No			cify Yes or No Ricen, etc.)	0- 14. R B	leck, White	ican Indien, , etc.
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raum traum		MARY ROBINS					SOUTHERN						
other		20e. Method of Disposition	UN /	DAUGITICK	20b. P		osition (Neme of	AVL.	1104	Dete	20c. Location		
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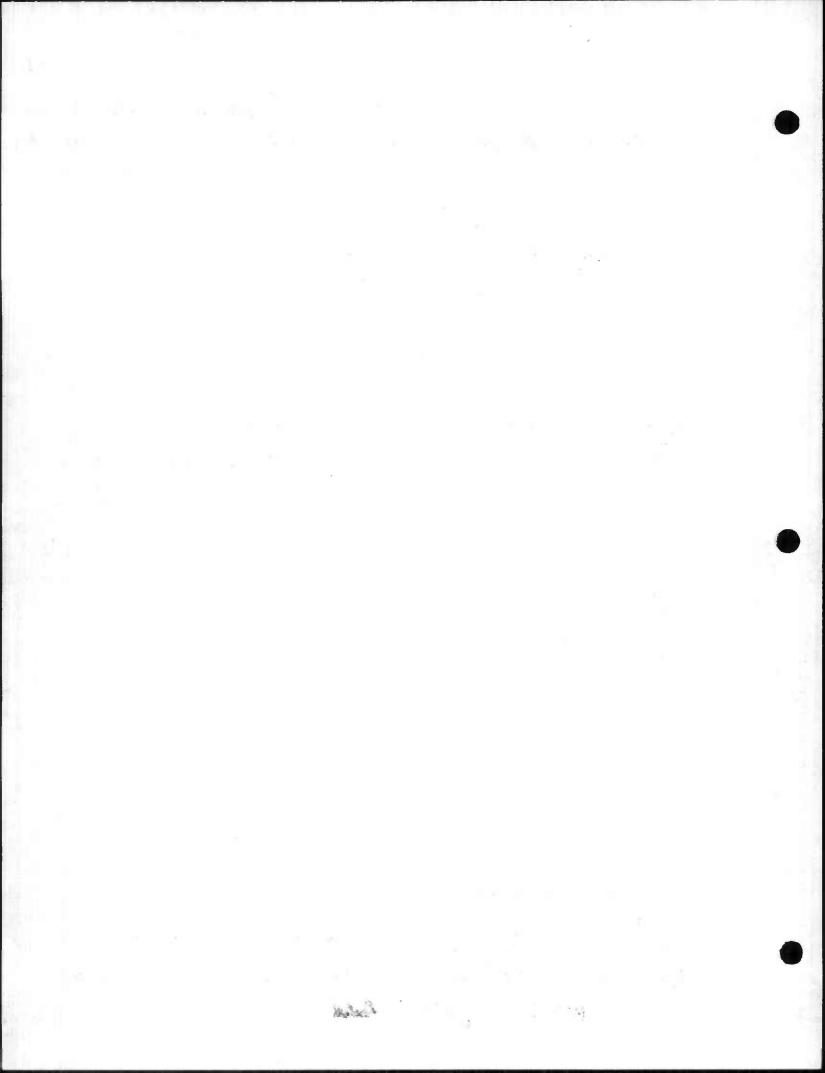
Registrar DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician
/Medical
Examiner

Physician/Medical à Completed Be 2 Certification: Medical

Funeral Director 10a State Director 288-11 Maryland 10e. Straet and Number 8 mant be Herrs 23a Completed by Funeral 11. Marital Status 'natural', or Item dical Examiner the Medical Hygiene. marked other Be Ħ of Health of Health of Health 27 is = 6 important: I any injury o 21. Sign /Medicai diate Cause (F) disaase or condition resulting in deeth) the buriel-tran physician USB BS signed by page 2 should be peen After this certificate has director, 1 Yas 2 No 27. Manner of Death

5. Social Security Number 187 32 1631 the Maryland 72 hours after Baltimore, Maryland 21215-0020 filed within Pages 1 and 2 should be nent of Health and Mental mus **Physician** Examiner The law requires that the deeth certificate be executed of Vital Records, P.O. Box 68760. nours after death.

neral Diractor: After this y filled in by the funeral di Division Attending 1 Naturel 2 Accident 3 Sulcide 4 ☐ Homicide 8 To the Hospital of within 24 hours all To the Funeral D completely filled

08358 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Jeannette Mary

4a. Facility Name (If not institution, give street and number) Pradel 2 1997 10:55 PM march 4b. City, Town, or Location of Death 4c. County of Death Plainview Prince e George's

9. Birthplace (Steta & Foreign
Country) Bowle ane If Under 1 Year 7. Aga (In yrs. lest birthday) If Under 24 Hrs Hours Min 1□ M 201 Months Days 54 Yrs July Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1☐Yes 2☐No Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 15807 Plainview Lane 20716 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian. Black, White, atc 1 ☐ Yes 2 ☑ XX If Yas, Give Year or Dates: 1 Never Married 2 X X Arried 1 Yas 2 XX 3 Widowed 4 Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Clerk U.S. Government 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Melden Surneme) John W. Baddy Loretta M. Everett 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) George J. Pradel 15807 Plainview Lane Bowie Maryland 20716 Husband 20a_Method of Disposition
1 Burial 2 Cramation 3 Ramoval from State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 4 Donation 5 Other (Specify) Resurrection Cemetery March 6, 1997 Clinton Maryland ture of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715 or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. ROSC/PROSLS Sequentielly list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dfd tobacco uss contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of causa of death? 24a. Wes an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Plece of Death (Check only one)

Other: 4 Nursing Home 1 ☐ fnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residance 6 Other (Specify) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stele) Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end placa, and due to the cause(s) end manner as stated. 29a. Certifier

29b. Signature and title of o

Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number TNW WASH DC 20036

31. Date filed (Month, Dey, Year

MAR 06

lik Davidson

DHMH 16 Rev 6/95

State

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08359 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 3 Pay MARCH 1997 BENJAMIN ROSENZWEIG 6:00 am /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SILVER SPRING MONTGOMERY HOLY CROSS HOSPITAL 5. Social Security Number If Under 24 Hrs. 7. Age (In yrs. lest birthdey) If Under 1 Year 8. Date of Birth 0272971908 9. Birthplace (State or Foreign NEW YORK **Funeral** 1☐M 2□ F Months Days Hours 89 578-46-9245 Director Usual Residence of Decedent 10b. County 10c. City. Town or Location or 28a-f show 10d. Inside City Limits must be notified at Director 1 ☐ Yes XXNo MARYLAND PRINCE GEORGES GREENBELT 10e, Street end Number 10f. Zip Code 10g. Citlzen of What Country? 20770 UNITED STATES herrs 23a 4 E CRESCENT ROAD Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give 11. Marltal Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Married Married ð Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3 Widowed 4 Divorced 'natural'. Year or Dates: Be Completed the Medical 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiene. ther than College (1-4or 5+) Elementery/Secondary (0-12) BRANCH CHIEF U.S. GOVERNMENT 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 should be and Mental is marked ISADORE ROSENZWEIG BERTHA SOLOMON 20 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Nem 27 is any Injury or other tra 4 E CRESCENT ROAD, GREENBELT, MARYLAND, 20770 ETHEL ROSENZWEIG(WIFE) 20b. Placa of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, State cametery, crematory or other place) XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING DAVID MEMORIAL GDNS 3/5/97 FALLS CHURCH, VIRGINIA 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical immediate Cause (Finel ACUTE MYOCARDIAL INFARCTION DAYS disease or condition resulting in death) **Examiner** Due to (or es e consequence of): Examiner **YEARS** CORONARY ARTERIOSCLEROSIS b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours efter death.
Puneral Director: After this certificate has been signed by the attending physician and bunai-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequenca of) P.O. Box 68760, Physician/Medical the Due to (or es e consequence of): use es deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, g Sign page 2 should Completed 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Wes an eutopsy performed? 2 No 1 ☐ Yes 2 No 1 ☐ Yes Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1XYes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Netural 1 Tyes 2 No 2 Accident filled in by the 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) end manner steted. 29a, Certifier completely To the Within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D08546 MARCH 4, 1997 30. Neme and address of person who completed cause of death (item 23a) (Type, Print)

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State

Registrar

31. Date filed (Month, Day, Yeer) MAR 0

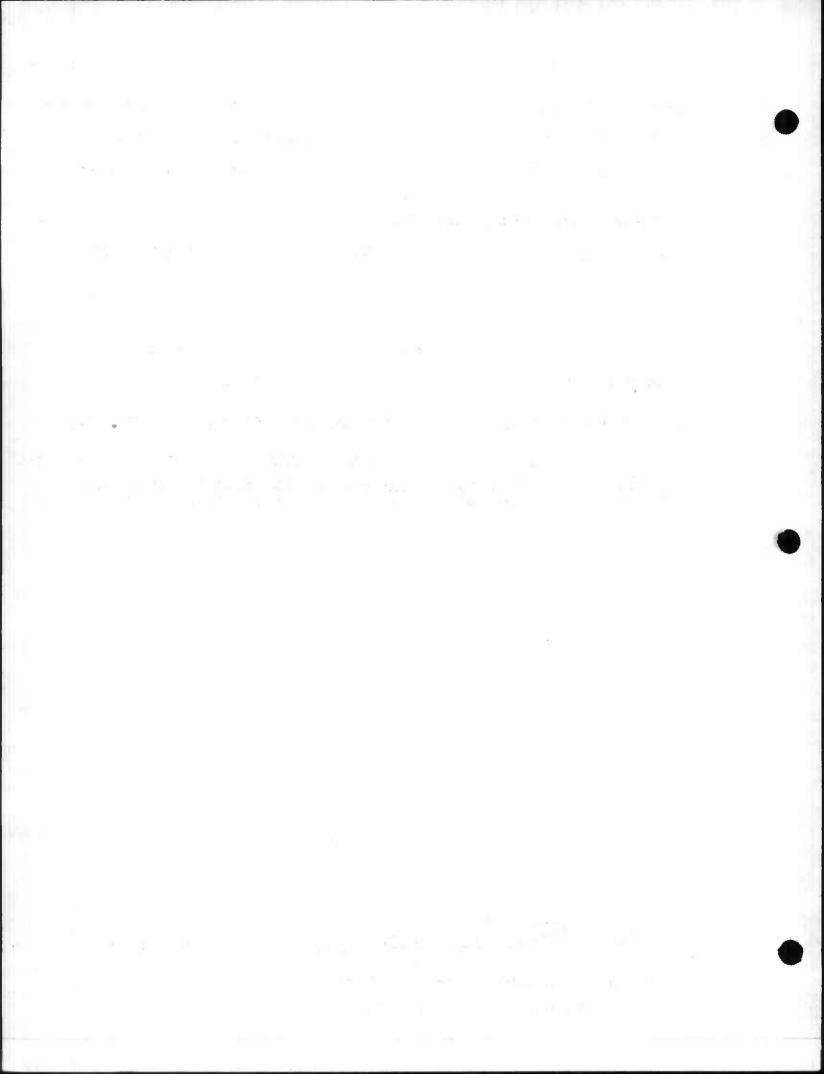
JOHN TAUBER

8218 WISCONSIN AVE 32. Registrar's Signature

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BETHESDA, MARYLAND

who Davidson-Randall



State of Maryland / Department of Health and Mental Hygiene

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Items: 23 part I, II, 27 per MEO G-746 4/10/97 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Day 28 **Physician** Month DAROLYN BONNIE RENZ **FEBUARY** 1997 7:30 AM /Medical 4e. Fecility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner LIBERTY MEDICAL CENTER BALTIMORE Baltimore 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplaca (State or Foreign Country) **Funeral** 1 ☐ M 2 ☑ F 579-48-1557 Yrs. 62 Director April 2,1934 South Dakota Usuel Residance of Dacadant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show Examiner must be notified at Director 1 Yes 2 □ No N.Y. Monroe Rochester 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 5 600 **Нетя 23а** Take Ave. 14613 Funeral U.S.A. 13. Was Decedant of Hispenic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexicen, Puerto Ricen, atc.) 12. Wes Decedant Evar in U,S. Armed Forcas? Race - Amarican Indien, Bleck, Whita, atc. 11. Marital Status should be filed within 72 hours effer ond Mental Hygiene.

marked other than "natural", or Her 1 Never Married 2 Married 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: by Specify 3 Widowed 4 Divorced White Completed traumatic event, the Medical 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) NONE 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) h end Mental F Be Peges 1 and 2 should be Darrell ٧. McCaig Twila V. Condron 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Department of Heelth el Important: If Ihem 27 Is any injury or other trainonce. Julie Dastvan 13612 Ambassador Dr. Germantown, MD. 20874 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20c. Location - City or Town, Stete 20e. Mathod of Disposition Data 1 ☐ Burial 2 ☑ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Chambers Crematory 3/3/97 Riverdale, MD. 21. Signature of Junaral Sarvica Licensee 22. Name and Addrass of Facility 670 Chambers Funeral Homes, P.A. 5801 Cleveland Ave. Riverdale, MD. 20737 Part1. Entar tha diseasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory errast, shock, or haart failura. List only ona causa on aach lina. Approximate Intarval Batween Onsat and Death **Physician** /Medical Immadiata Causa (Final CARDIAC ARRHYTHMIA disaase or condition rasulting in daath) Examiner Dua to (or as a consequance of): Examiner physician and the burial-transit The law requires that the death certificete be executed Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarfying Causa (Disaasa or Injury that Initiated avants resulting in deeth) Lest Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Dua to (or es a consequance of): 80 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown SCHIZOPHRENIA signed b Records, þ 24b. Wara autopsy findings availabla prior to complation of cause of daath? Completed 24a. Was an autopsy performed? page 2 1 Nas 2 No Mas 2 No certificate Division of Vital Hospital or Attanding Physician: Be 25. Was casa rafarred to medical 26. Placa of Death (Check only ona) axaminar? XXYas 2□ No Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To Inpatiant 2 ER/Outpatient 3 DOA this funeral 28e. Data of Injury (Month, Day Year) Mannar of Death 28h Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? After XX Natural 5 Pending death. 1 □ Yas 2 □ No Invastigation 2 Accidant ofter death Director: 6 Could not be datarminad 3 Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 2 4 Homicida 2 within 24 hours e To the Funeral C completely filled filled 29a. Cartifiar Medical 1 Cartifying Physician: To tha bast of my knowladga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as statad. (Check only one) Madical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. Licensa number 29d. Data signed (Month, Dey, Year) O.C.M.E. FABUARY 28, 1997 Nama and addrass of person w plated causa of daath (Item 23a) (Type, Print) hutemp ennis Penn Street, Baltimore, Maryland 21201 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State MAR 0 4 1997 Registrar

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 08361 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time th Mont Day Grace Elizabeth Rosen 1997 March 8:32 AM 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital Randallstown Baltimore 8. Date of Birth (Month, Dey, Year) Oct 7, 19 If Under 1 Yaar Months Days If Under 24 Hrs. Houra Min. 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplaca (State or Foreign Country)
 Mary Land 1 ☐ M 2 ☐ XF Yrs 64 219-28-9375 1932 Usual Residence of Decedent 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2K No Maryland Baltimore Owings Mills 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 48 Hiawatha Court 21117 United States 12. Was Decedent Evar in U,S. Armed Forces? 11. Maritai Status Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. Biack, White, etc. 1 ☐ Yas 2 ☒No If Yes, Give Yaar or Dates: 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) Cashier unknown Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Wessel Vivian Propst 19a. informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) William K. Stultz/Son 5107 Crystal Park Lane Ellicott City, MD 21043 20b. Placa of Disposition (Name of cametery, cramatory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Buriai 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul's Cemetery 3-5-97 Fulton, Maryland 21. Signature of Funarai Sarvice Licenses 22. Name and Address of Facility Harry H. Witzke Funeral Home, Inc. Gle a 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one causa on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) Arteriosclerotic Cardiovascular Disease Years Due to (or es a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 22 No 1 ☐ Yas 2 ☐ No 25. Was case raferred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify) 1⊠ Yes 2 No 1 Inpatient 2% ER/Outpatient 3 □ DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicat Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and mannar stated. 29a. Carttlio 29b: Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) elever D11171 March 1, 1997

State Registrar

Physician

/Medical

Examiner

Funeral

Director

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1 and 2 should be filled within 72 hours after Health and Mental Hygiene. em 27 is marked other than "netural", or the

Pages 1 and 2 ment of Health 1 ant: If Item 27 is

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Hospital or Attending F 24 hours efter death. Funeral Director: After

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Baltimore,

Division of Vital Records, P.O. Box 68760

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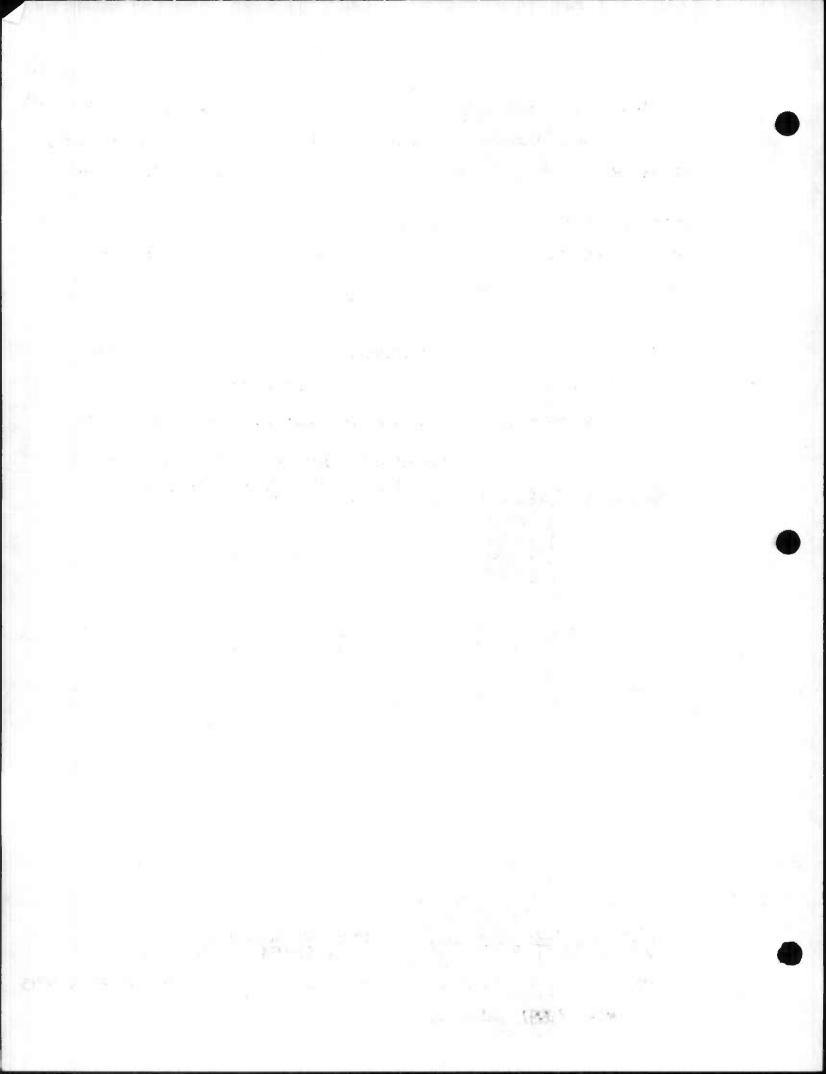
E.P. Williamson II 405 Frederick Avenue Catonsville, Maryland 21228 32. Registrar's Gignature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene

08362 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 01:50 A.M. ROY ROGERS 04 MARCH 1997 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner LAUREL REGIONAL HOSPITAL PRINCE GEORGES LAUREL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Ye June 12, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** MM 2□ F 213-32-5567 Yrs Director 64 1932 Maryland Usuai Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Director 1 ☐ Yes 2 XNo Maryland Howard Jessun 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? b Itams 23a 10167 Guilford Road 20794 United States Funeral 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates: Baltimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 ☑ No Specify: P Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) Draftsman Federal Government marked other 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) th and Mental 1 Pages 1 and 2 should be Roy L. Rogers Sr. Lena Baker 19a. Intorment's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If Itam 27 is any injury or other tra once. Randall J. Meyers/Brother 10909 Brennan Court Columbia, Maryland 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State b 1 ☐ Buriai 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balt-Washington Crematory 3-6-97 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Harry H. Witzke Funeral Home, Inc. Collins thee 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** immediate Cause (Final diseasa or condition resulting In death) /Medicai . ARTEKIO SCUEROTIC CARDIOVASCULAR DISEASE Examiner Due to (or as a consequence of) Examine sician and burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in death) Last Due to (or es a consequence of) physician the burial P.O. Box 68760, Physician/Medical Due to (or as a consequence of): signed by the et Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings availabla prior to completion of cause ot death? Completed 24a. Was an autopsy performad? page 2 2 No 1 Yas 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: Certification: To Yes 2□ No Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) 2 ER/Outpatient 3□ DOA 1 Inpatiant funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 24 hours after death. 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, daath occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier completely (Check only one) within 2 To the ŝ 29b. Signature and title ot certifiar 29c. License number 29d. Date signed (Month, Day, Year) DEPUTY MEDICAL EXAMINER D 33454 MARCH 05, 1997 ed cause of death (Nem 23a) (Type, Print) 30. Name and address of person who con 41.D HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785 JR 3001 MARIO F. 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature State Habi Devilear Replett Registrar MAR 07



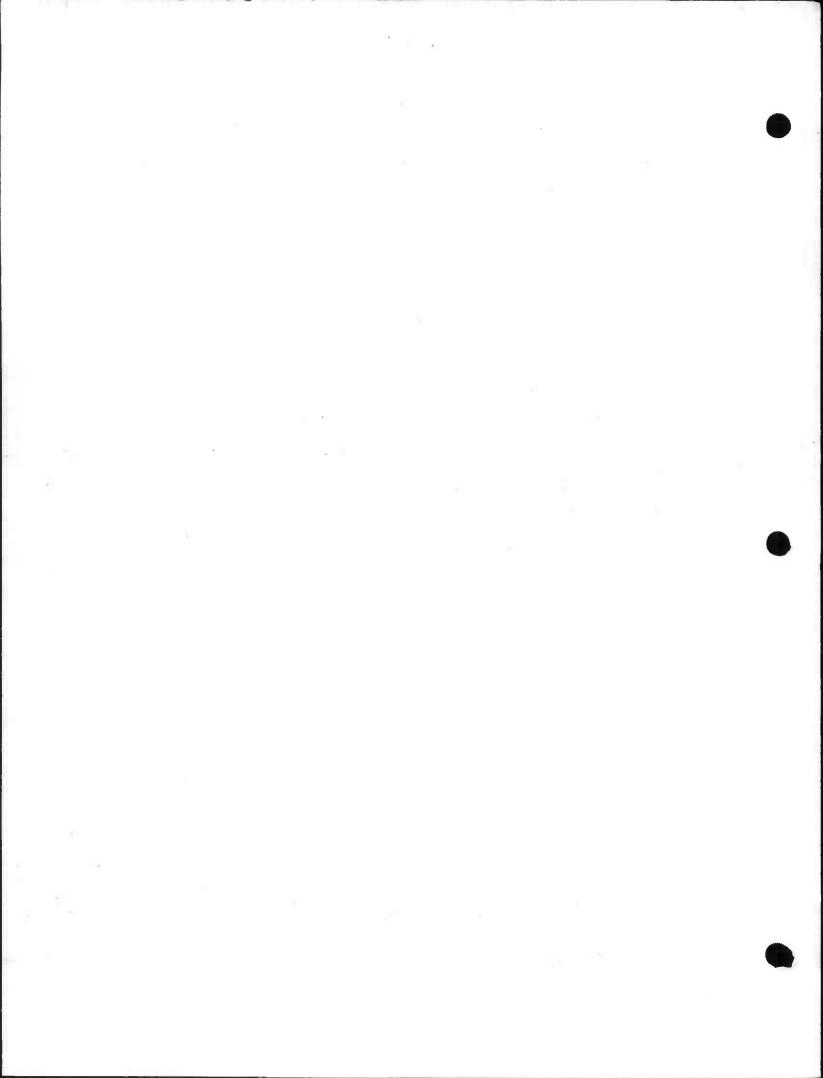
State of Maryland / Department of Health and Mental Hygiene Q7 08363

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uneral	5. Social Security Number 220–56–1411	6. Si	ax □M 2DXF	7. Aga (In yrs. 56	last birthday) Yrs.	Months	T 1 Yaar Days	If Undar 2 Hours	Min.	B. Data of Birth (Month, Day Oct 23,	Year)	9. Birthpi Coun	laca (Stata or Foreign try)
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by Physician	Part II. Other eignificant co	onditions co	entributing to de	ath but not ras	ulting in tha u	ndarlying o	causa giv	en in Part I.			obacco uee co		the cause of death?
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y the fune	3 Suicida 6 4 Homicide	datarmined	reician: To the iner: On tha ba and menn	sia of axamina	wledga, death tion and/or In	n occurred vastigation	at tha tir , in my o	ma, data and opinion, daati	place, an	d dua to the ca d at tha tima, d	ause(s) and m lata and placa,	anner as st and dua to	ated. tha causa(s)
fication	3 Suicida 6 4 Homicide 29a. Certifiar 1 Check only 2 Me	datarmined ortifying Phy odical Exam	reician: To the	sia of axamina	wledga, death tion and/or In	vastigation	i, in my o	pinion, daati a number	occurred	dat tha tima, d	ata and placa,	and dua to	tha causa(s) Day, Year)
fication	3 Suicida 6 4 Homicide 29a. Certifiar (Check only one)	datarmined ortifying Phy odical Exam	reician: To the	sia of axamina	wledga, death tion and/or In	vastigation	i, in my o	pinion, daati	occurred	dat tha tima, d	ata and placa,	and dua to	tha causa(s) Day, Year)
ctor: After y the fune fication	3 Suicida 6 4 Homicide 29a. Certifiar (Check only one)	ortifying Phy ordical Exam certifiar	velcian: To the iner: On tha be and menr	sia of axamina er stated.	tion and/or In	vastigation 29 Print)	c. Licans	ppinion, daati sa number S974	occurred	d at tha tima, d	ata and placa,	and dua to	tha causa(s) Day, Year)
To the Funeral Director: After completely filled in by the fune Medical Certification	3 Suicida 4 Homicide 29a. Certifier (Check only 2 Me core) 29b. Signature and titla of core) 30. Nama and addrass of p	ortifying Physical Example Certifiar Physical Example Physical Example Physical Phys	reician: To the iner: On tha ba and menr	sia of axamina er stated.	1 23a) (Type,	vastigation 29 Print)	c. Licans	ppinion, daati sa number S974	occurred	d at tha tima, d	ata and placa, 19d. Data signe	and dua to	tha causa(s) Day, Year)

					Certificate of	Death	Re	eg. No.	97 08364
	Dhari		Decedent's Name (First, Middle, Last)				2. Dete of Deat	h	3. Time of Death
	Physici /Medi		Mary Edna Ridgel	4	•		March	Day	Year 11: 41 PK
	Exami		4a. Facility Name (If not institution, give street and number,	1		4b. City, Town, or L		4c. County	of Death
13			Fallston General Hospital			Fallsto	n	Harf	ord
	uneral lirector			ge (In yrs. last birt	thday) if Under 1 Year Months Days		8. Date of Birth (Month, Day, Oct. 1,	Year) 1920	Birthplace (State or Foreign Country) Maryland
24	* u		10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits
the Maryland	28a-f sh notified a	Director	Maryland Harford	Abir	ngdon			On Citimes of M	1 ☐ Yes 2 反 No
ath with	s 23e ov nuel be r	rai Dir	3821 A. Memory Lane		10f. Zip Code 21009		10	og. Citizen of W USA	
21215-0020 d within 72 hours after de piene.	then natural, or lears 23s or 25s-1 show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 12. Was Decedent Armed Forces? 1 □ Yes, Give Year or Dates:	All Section 1	13. Was Decedent of if Yes, specify Cul	ban, Mexican, Puerti	pecify Yes or No- Rican, etc.)		a-American Indian, k, White, etc. White
2 2	disal	Completed	15. Decadent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occu (Give kind of work done	ipation	cina	16b. Kind of Bu	siness/Industry
within	14	Idu	Elementery/Secondary (0-12) College (1-4or	5+)	life. DO NOT use retin	ed)			
	A ST		9	Di	ietitian				Government
Maryland d2 should be file	e ve	Be	17. Father's Name (First, Middle, Last)				e (First, Middle, N	_	a)
y Sould	and o	ို	Joseph (u/k) Scarlotta			Virgini		Reed	
Aar 2 mh	1 1		19a. informant's Name/Relationship (Type, Print)		Malling Address (Stree				
0.7	Item 27 other b		Lillian A. Malee - Daughter		S. Frankl	in St., R			7356
Baltimore, semil. Pages 1 s Department of Hea			20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State	comotos	Disposition (Name of y, crematory or other pla	ace)	Date 2	20c. Location -	City or Town, State
E and	Important: If any injury o otice.		4 Donation 5 Other (Specify)		and Memoria	1 Park 3	-5-97	Baltimo	re, Maryland
Balt permit.	mport any in		21. Signature of Funeral Service Licensee		22. Name and Addr		TTT These	out Lond	
m 8.6	5 5 8		Atolk Collins	1,	HOWard K	. McComas	TII FUN	eral HO	21009
11-			23a. Part F. Entsythe disease, or complications that sause shock, or heart failure. List only one cause on each in	the death. Do n	ot enter the mode of dy	ing, such as cardiac	or respiratory arre	st,	Approximate
Phy	sician		andox, or rear failure. Cat only one cause diveaus	ne.					Interval Between Onset and Death
/M	ledical		Immediate Cause (Final disease or condition	1100	Arrhyth	4.4.4.4			41 tu minutes
Exa	aminer		resulting in death)	Due to (or as a c	onsequence of:	MIG		1	Thirty minutes
7		ner	A+1.	017 51	100 1	Costin	100001	ac lis	ecco tenupari
X 58 / 50, artificate be executed	attending physician and for use as the burial-transit	Examiner	Sequentially list conditions	Due to (or as a c	onsequence of):	(4,010	Vascal	41 (11)	thirty minutes ease ten years
C S	an ar		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.						
OS/OU,	ysici ne bu	edicai	that initiated events	Due to (or as a co	onsequence of):				
tifica	as th	Med	resulting In death) Last	(
ath cert	esn.		d						
de ag	ed by the attendin detached for use	Physician/	Part II. Other significant conditions contributing to death b	ut not resulting in	the underlying cause of	iven in Part i	23h Did tol	nacco use con	tribute to the cause of death?
at the de	ache	hys	of the control of the	at not resulting in	the underlying cause gi	WOIT III P and I.			3 Probably 4 Unknown
tha tha	signed d be del	by P					10.0	2 2 140	O TOURISM
The law requires that the death or	peed	Completed to					24a. Was ar perform	autopsy led?	24b. Were autopsy findings available prior to completion of cause of death?
E e	age 2	EO					1 ☐ Ye	s 2 No	1 ☐ Yes 2 ÛNO
	s certificate ha director, page	Bec	25. Was case referred to medical			26 Place of Dog	th (Check only one		10100 2000
	S cert	0	examiner? 1 ☐ Yes 2 No Hospital: 1 Minpatie	nt 2 TEP/Out	patient 3 DOA Ot	hor:	ome 5 Reside		- (Casaika)
DIVISION OF or Attending Phys after death.	5 70 1	F 1	27. Menner of Deeth 28a. Dete of Inju	ry 28b. Ti			28d. Describe ho		
Attending r death.	ractor: After I by tha funer	tlor	1 XNatural 5 ☐ Pending (Month, Da 2 ☐ Accident Investigation			ork?]Yes 2 □ No		,	
or Attendi	Director: I in by tha	fica	3 Suicide 6 Could not be 28e Place of Ini	urv - At home, far	m, street, factory, office		28f. Location (Str	eet and Numbe	or or Rural Route Number.
afta	5 - I	Certification:	4 Homicide determined building, ele	: (Specify)	, 51.551, 125151, 511155		City or Town,		
To the Hospital or within 24 hours after	To the Funeral I completely filled		29a. Certifler 12 Certifying Physician: To the best	of my knowledge	doeth coourred at the ti	ima data and place	and due to the on	uno(a) and mass	
Hod 24 h	Fun	edical	(Check only one) 2 Medical Examiner: On the basis of and manner str	examination and	or investigation, in my	opinion, death occur	red at the time, da	te and place, a	nd due to the cause(s)
thing the	of the	M	29b. Signature and title of certifier		29c. Licen	se number	20	d Date signed	(Month, Day, Year)
¥ 3	F 8		DM 01-0/10	1) -					5 ,967
		-	1 / why we	y he	v a	35522	- /	Narch	4, 1177
			30. Name and address of person of completed cause of d	1th A	Type, Print) Venue	Bel A	r Mar	yland	21014.
	Sta Registra	-	31. Date filed (Month, Dey, Year) MAR 3 1997	ars Signet	all		/		

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires the TO THE FUNERAL DIFFECTOR: After this cenfidiate has been signed be filed within 72 hours after death with the State Dept. of Health; is IMPORTANT if item 28 is marked on them 23 shows an
TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and compelledy filled in by the funeral director, page 5 should be detached to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMADIFICATIVE is in marked, or them 23 shows any Intury, or other tranmatic event, the medical examiner must be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior IMPERTANT: If item 28 is marked on them 23 shows any Injury, or other train
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death of THE FUNERAL DIFFECTOR: After this cenflicate has been signed by the attend TO THE FUNERAL DIFFECTOR: After this cenflicate has been signed by the attend TO THE FUNERAL DEATH of Health and Mental HIMPORTANT: It item 28 is marked on them 23 shows any Injury on
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that TO THE FUNRAL DIRECTOR: After this centificate has been signed be filed within 72 hours after death with the State Dept. of Health is IMPORTANT: if item 28 is marded or them 23 shows an
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law TO THE FUNERAL DIRECTOR: After this certificate has I be filed within 72 hours after death with the State Dept IMPORTANT: 14 Heart 28 Is an arched or Herr 23.
TO THE HOSPITAL DR ATTENDING PHYSICIA TO THE FUNERAL DIRECTOR: After this certi be filed within 72 hours after death with the IMPORTANT: It item 28 is marked, or
TO THE HOSPITAL DR ATTENDI TO THE FUNERAL DIRECTOR: A be filed within 72 hours after de
TO THE HOSPITAL I TO THE FUNERAL D DE filed within 72 h
TO THE P

	REGISTRAR		CERTIF	ICATE C	F DEATH	REG	. NO.			
	t. DECEDENT'S NAME (First, Middle, Last)	//	10			2. DATE OF DE	DAM	YEAR	3. TIME OF DE	ATN
	Margaret Eliz	a bet	1/40	se		2/	27	97	122	PM
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In	yrs, last birthday)	IF UNDER 1 YE		7. DATE OF BIRT	TN her)	8. BIRTN	PLACE (State or i	Foreign
	234-44-6615 t M 2 [5 YRS.		YN OR LOCATION OF DE	June 1		W. T	/irginia	a
DIRECTOR	Springbrook Adventist N		Home		er Spring	-AIN		tgome		
띫	ton, STATE 10b, COUNTY		10c. CIT	Y, TOWN OR L	CATION				tod. INSIDE CIT	TY
	Maryland Harford		B	el Air					LIMITS?	
FUNERAL	711 Cedar Lane				tof. ZIP CODE 21015		1 7	TIZEN OF V USA	VHAT COUNTRY?	
B	1 Never Married 2 Married FORCES	CEDENT EVER IN ? 1 YES GIVE WAR OR DAT	2 XNO	It yes	DECENDENT OF NISPAI s, specify Cuben, Maxica YES 2 NO Specif	in, Puarto Rican, e		14. RACE Black Speci	- American inc k, Whita, atc.	dlan,
	ts. DECEDENT'S EDUCATION (Specify only highest grade completed)		ten. DECEDENT'S	work done durin	PATION g most of working	16b. KIND (OF BUSINESS/IN	IDUSTRY		
COMPLET	Elementary/Secondary (0-12) College (1-4	or 5+)	iii. Do NOT U			Dry	Clean	ina		
<u></u>	t7. FATHER'S NAME (First, Middle, Last)				18. MOTNER'S NA	ME (First, Middle, I				
BE 0	Nathanial Ward Neely				Susan	Mariah	n Bowe	rs		
6	t9a. INFORMANT'S NAME (Type/Print) EMOTY S. ROSE				eet and Number or Rural				2090	6
	20a. METNOD OF DISPOSITION	20b.	PLACEANDDATE				0c. LOCATION -			
	1 💢 Burtal 2 □ Cremation 3 □ Removal from Sta 4 □ Donetion 5 □ Other (Specify)	ta ceme	tery crematory or o	other place)	L Gardens	1			Marylan	d
	21. SIGNACUME OF AUNERAL SERVICE LICENSEE	100		HOW	and Address of FA	omas II	[Funer	al Ho	ome, P.	Α.
	23, PART I. Enter the diseases, or complication	o that caused	the deeth. Do		7 Cokesbur				Approxi	
	shock, of Heert failure. List only or iMMEDIATE CAUSE (Fine)	e cause on ee	ch line.				,		interval	Between nd Death
		EJM		PFI:	Λ				3 1	nts
z	In	paire	d Ga	9 Re	Accido				>1	71.
AT 10	Sequentially list conditions, if sny, leeding to immediate cause. Entar UNDERLYING	UE TO (OR AS A	CONSEQUENCE	p: /	1	. 4			>	
일	CAUSE (Diseasa or injury that initiated events	UE TO (OR AS/A	CONSEQUENCE C	0 (4)	1100141	1/			Ma	47
CERTIFICATION	resulting in deeth) LAST	perte	ns; en						yes	275
DICAL C	PART II. Other significent conditions contribut	ng to deeth bu		in the under		P	AS AN AUTOPS' ERFORMED? YES 2 NO	Y 24b	WERE AUTOPSY AVAILABLE PRIO COMPLETION OF OF DEATN?	R TO
ME	DID TOP ACCOUNT CONTRIBUTE TO	CALICE OF	DEATH V	56 T NO	- INICESTAL				t 🗆 YES 2 🛭	NO
PHYSICIAN: ME	DID TOBACCO USE CONTRIBUTE TO 25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEA			N 🖸				
SIC	EXAMINER? 1 YES 2 NO 1 Inpatia	L: nt 2 🗆 ER/Outpu	itiant 3 DOA	OTHER:	Home 5 🗆 Rasidenca	8 Other (Speci	fy)			
PH	(M	ATE OF INJURY onth, Day, Year)	28b. Till IN		INJURY AT WORK?	28d. DESCRIBE		CCURED		
BY	1 Natural 5 Pending 2 Accident Investigation	105 05 W NOV			YES 2 NO					
9	3 Suicide 8 Could not be but determined	Iding, stc. (Speci	— At home, term,	street, tactory,	offica	City or Town	Street and Numb , State)	er or Rural I	Route Number,	
COMPLETE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the bar								a) and manner	atated
	296, SIGNATURE AND TITLE OF CERTIFIE	A A		, my opini						
B	South one in the or certified	# M	TD		29c. LICENSE NU	MBER / (20)	29d. D/		28/97	7
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETE	D JAUSE OF DEA	TH (ITEM 27) (Typ	e, Print) 7	reenbely	eenvra	y Cn	70.	Dr. #	430
	3t. DATE FILED (MONTH Day, Year) 4007 32. RB	STRARA SIGN	TURE A	6.4	reenbely	md.	20%	70		
	MAR 3 199/ 3	Line of the sale	ser land	K						



State of Maryland / Department of Health and Mental Hygiene 08366 Certificate of Death 1 Decedent's Name (First Middle Last) 3. Time of Deeth 2. Dete of Deeth **Physician** AYNE 1997 TEDENARY 27 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Harford Fallston Fallston General Hospital If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. Birthplece (State or Foreign Country)
 New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10M 2□ F Months Deys Yrs. Director 83 1914 111-03-9528 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside Cltv Limits Norte 23s or 28s-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** Willow Street Lancaster Penna. 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA 17584 313 Nolte Avenue 12. Wes Decedent Ever in U,S. Armed Forces? Race - American Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Never Merried 2 ☐ Marrled 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 8 Balfimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3[™] Widowed 4 □ Divorced Specify: White "natural" Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondery (0-12) Coilege (1-4or 5+) Office Manager Manufacturing 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be h and Mental it Acker Fayette Rogers (u/k) 20 traumetic 19a. informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) important: if item 27 is any injury or other 219 E. Ring Factory Rd., Bel Air, MD Pamela R. Schott - Daughter 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ⊠Buriel 2 ☐ Cremetion 3 ₺ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Chemung, N.Y. Chemung Cemetery 3-1-97 22. Name end Address of Fecility Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 23e. Pert1. Enter the full see, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear full re. List only one cause on each line. Approximate Intervei Between Onset and Deeth **Physician** immediate Ceuse (Finei diseese or condition resulting in death) /Medical Examiner Examiner HEART To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours effer death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely littled in by the funeral director, page 2 should be detached for use as the bunishmanit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest attending physician for use as the burial Box 68760. Physician/Medicai Due to (or es a consequence of) Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings evalleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 2000 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) examiner? 2 Other: 4 Nursing Home 5 Residence 8 Other (Specify) inpatient 2 ER/Outpetient 3 DOA 28c. Injury et Work? 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of Certification: Neturel 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Sulcide 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end manner es steted.

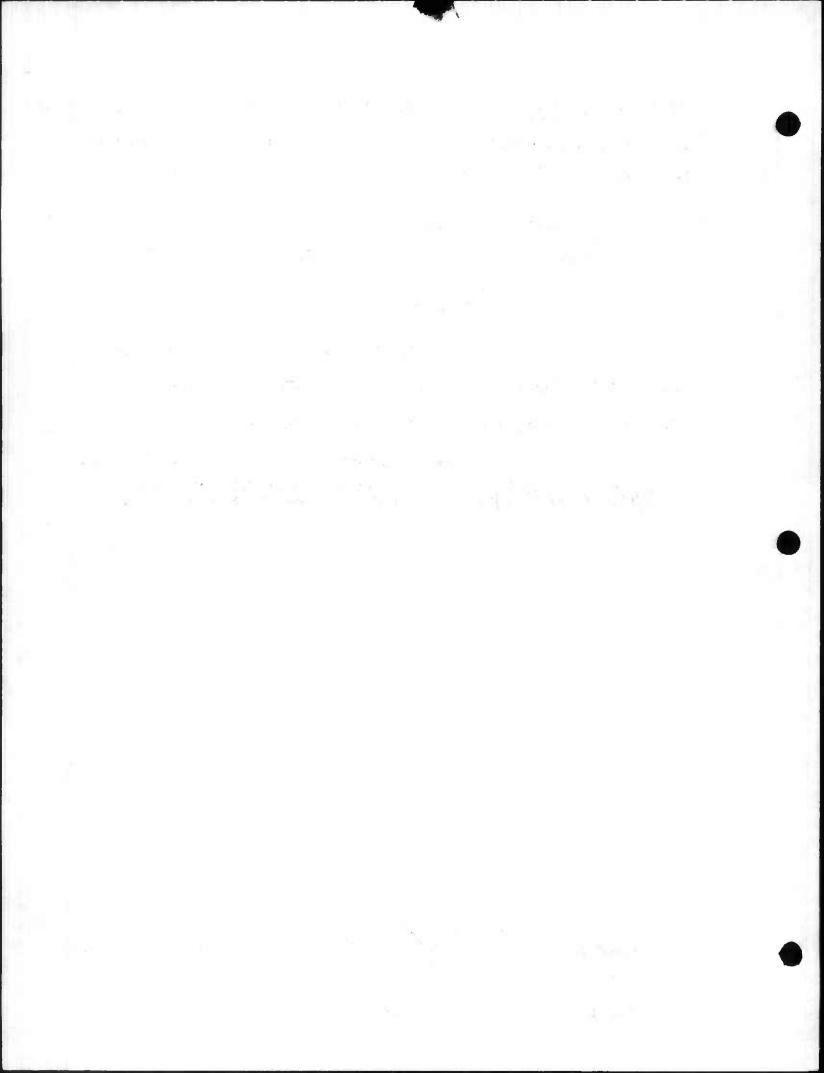
Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) and manner er steted. Medicai 29a. Certifier 29b. Signiture and title of certifier 29d. Dete signed (Month, Dev. Year, 30. Name and address of person who completed cause of deeth (item 23e) (Type, Print) 32. Registrer's Signeture 31. Dete filed (Month, Dey, Yeer) State

DHMH 16 Ray 6/95

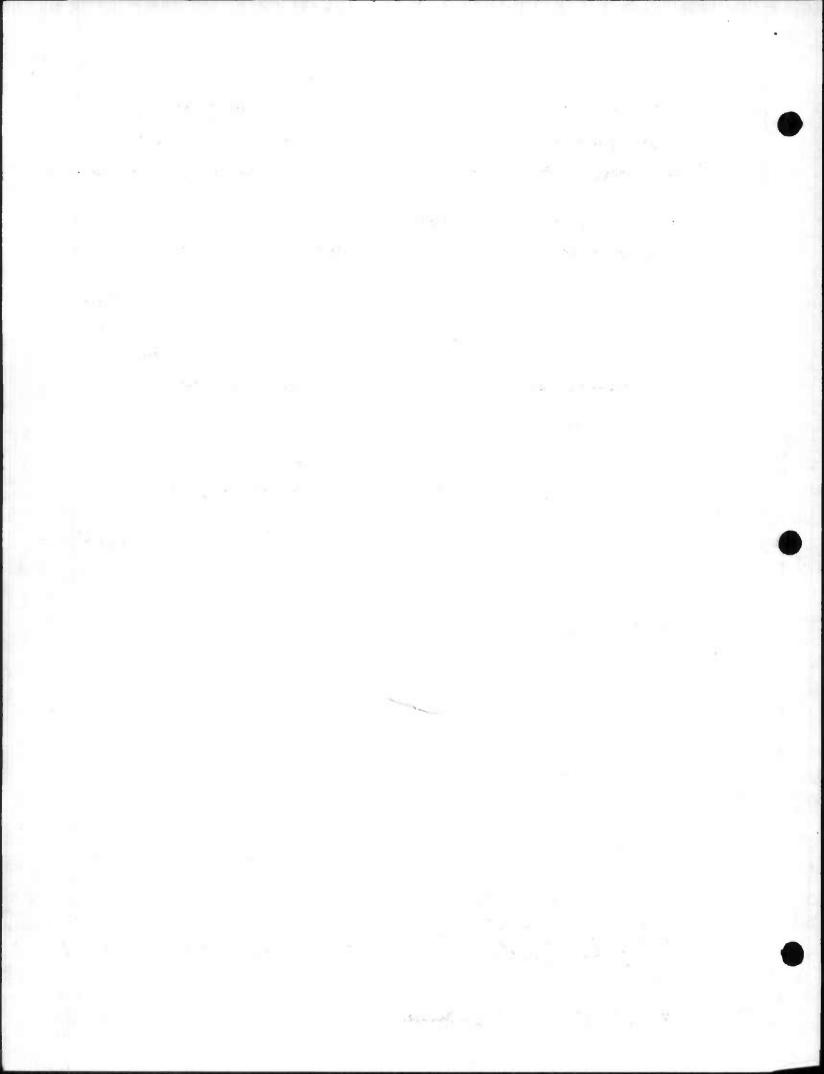
Registrar

1997

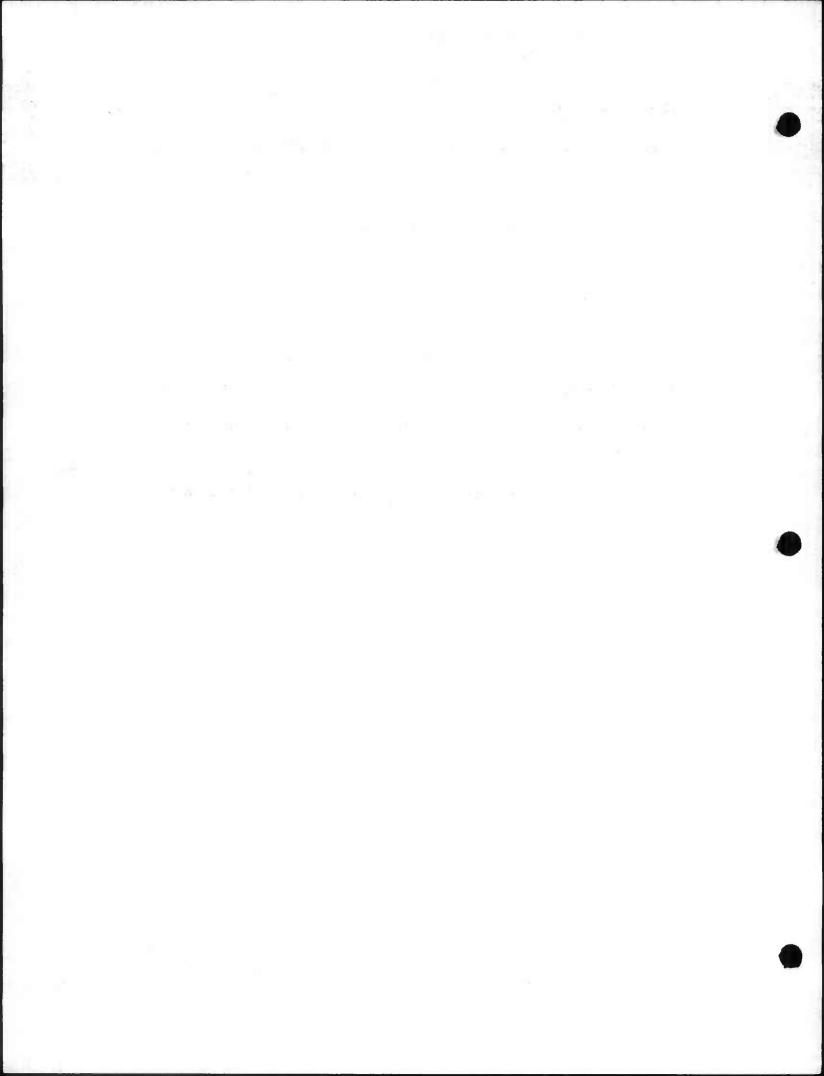
MAR 4



		State of	of Maryland /	Department Certifica			nd Menta		ene ı. No.	97	08367
Physic		Decedent's Name (First, Middle, Last) Hoover Ray Roland						te of Death	Dey 9 7	Year	3. Time of Death
/Med Exami		4e. Facility Name (If not institution, give street and nu 1636 Colora Rd	mber)			4b. City, Tow	n, or Location		4c. County		DIO I GAI
Funeral Director	Γ	5. Social Security Number 6. Sex 1 1 20 7095	7. Age (In yrs. last b	Yrs. If Under Months	or 1 Year Days		4 Hrs. 8. Da Min. (M	te of Birth onth, Dey, Y	'ear)	9. Birthp	place (State or Foreign http) Sylvania
anyland show d.at	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location							Od. Inside City Limits
with the M s or 25a-f be notified	Director	MD Cecil 10e. Street end Number 1636 Colora Rd	Color		p Code	917		100	. Citizen of V	What Cour	1 ☐ Yes 2 M No
-0020 hours after death with the Marylar ursh, or items 23s or 28s-f show at Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 1 Never Married 2 Married 1 See Si	2 🗌 No	13. Was Deca	dent of h		n? (Specify Ye Puerto Rican,	es or No- etc.)	14. Rac	e - Americ ck, White,	
orithin 72 ho	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (16	Ge. Decedent's Usu (Give kind of we life. DO NOT	ork done ise retire	pation during most of d)	of working	16	b. Kind of Bi	usiness/Ind	dustry
aryland 2 should be filed v of Mental Hygie marked other t made event, th	To Be Co	8 17. Father's Neme (First, Middle, Last) John Heary Rowhand		Molde	r		s Name (First,			10)	
Battimore, Maryland 21215-0020 permit. Pages I and 2 should be fluid within 72 hours at Department of Health and Mental Hygiene. Important: If item 27 is newfeed other than "natural", or important: If item 27 is newfeed other than "natural", or any injury or other traumatic event, the Medical Examploice.		19a. Informent's Name/Relationship (Type, Print) Hoover Roland, Jr. Son 20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify) 21. Signeture of Funeral Service Licensee	State 20b. Piace cement Penns	יוי מ	me of other pla	St La ce) March ess of Facility	Dete	PA 20	17603 c. Location · each E	City or To	wn, State
Physician /Medical Examiner	er.	23a. Part1. Enter the disease, or complications they shock or heart feilure. List only one cause of a Immediate Cause (Final disease or condition resulting in death)	SOVD	111 So not enter the mo	Que de of dyli	en St.	Risin ardiac or respi	g Sun ratory arres	MD 21	911	Approximate Interval Between Onset and Death
rificate be executed ng physician and as the burial-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting In death) Last	HIII - CA S	e consequence of):		7					
hat the death certific of by the attending p detached for use as	Physician/M	Part II. Other significant conditions contributing to de		in the underlying	ause giv	ren in Part I.	20		cco uae coi		the cause of death?
w requires t s been sign 2 should be	Completed by	7,700					24	a. Was en e performe	eutopsy d?	ava con	ere autopsy findings alleble prior to mpletion of cause death?
ysician: The law ysician: The law is certificate has director, page 2	Be Com	25. Wes case referred to medical exeminer?				26. Plece o	f Death (Chec	1 ☐ Yes	212 No	10	Yes 2 No
sion eath. or: After the fune	Certification: To	1 Yes 2 No		Time of Injury M	28c. Injur Wor 1 □	4 LI NUIS	28f. Loc	escribe how	Injury occurr	ed	/) I Route Number,
To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical	29e. Certifier (Check only one) 1 Certifying Physician: To the be and mann	asis of examination at	ge, death occurred ind/or investigetion	et the tir , in my o	ne, dete and p pinion, deeth	placa, and due occurred at th	to the cause time, dete	se(s) and ma and place, e	nner as st and due to	ated. the cause(s)
Yoth Toth Comp	Me	20th. Signature and title of certifier 30. Name and address of person who completed caus	e of death (Item 23a))	D.	e number 480	66		Dete signed		Dey, Year) 1997
10+1VA	ite	Sara Sutherland, MD			ı MD	21921					



				Certificate of Death	Reg. I	No. 9 /	08368
П	Dh		Decedent's Name (First, Middle, Last)		2. Date of Death	Day Vans	3. Time of Death
	Physici /Medi		RICHARD A	SPICER		Day Year 199	7 3:22 PM
	Examir		4a. Facility Neme (If not institution, give street and number)	4b. City, Town, or		4c. County of Death	
1			Washington Adventist Hospital	Takoma P	ark	Montgome	rv
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las		S. 8. Dete of Birth		hplace (Stete or Foreign untry)
	Director		212-64-4126	Yrs. Months Days Hours Min	Nov. 17,1		ington, D.C.
	fand M Ost			Town or Location			10d. Inside City Limita
	with the Maryland a or 28a-f show Lbs notified at	ţ	Maryland Prince George's	Hyattsville			1 ☐ Yes 2 ☐ No
	r 28s	Director	10a. Streef end Number	10f. Zip Code	10g.	Citizen of What Cou	unfry?
	h with		6601 Karlson Court	20783		U.S.A.	
	dead dead	Funeral	11. Merifel Stetus 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	14. Race - Amer	
0	after death with the Marylar or Items 23a or 28a-f show iminer must be politied at		Armed Forces? 1\(\sum \) Never Merried 2\(\sum \) Merried 1\(\sum \) Yes 2\(\sum \) No		to Hican, etc.)	Bleck, White	i, etc.
92	100 - 700	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Yeer or Dates:	1 ☐ Yea 21 No Specify:		Specify: W	hite
Maryland 21215-0020		Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent'a Usual Occupation (Give kind of work done during most of wo	16b.	. Kind of Buainess/l	ndustry
2	within than the Men	ğ	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of wo tife. DO NOT use retired)	The same of the sa		
2	NA STORY			lectronic Technician		lectronic:	S
Ë	d day	Be	17. Father'a Name (First, Middle, Last)		ame (First, Middle, Meid		
F	Marka Marka Marka	1º	Kenneth J. Spicer		red V. Park		
Mai	12 and 12 and 13		19a. Informant'a Name/Relationship (Type, Print)	19b. Meiling Address (Street end Number or R	urel Route Number, Cit	y or Town, Stete, Z.	ip Code)
	1 and feedth m 27 ther			8957-J Edmonston Road se of Disposition (Neme of			
ō	a to the		1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removal from State	etery, cremetory or other place)	Date 20c.	Location - City or T	own, Stele
Saltimore,	the Pa		4 □ Donation 5 □ Other (Specify) Metr	opolitan Crematory	3/5/97 Ale	xandria,V	/irginia
gal	permit. Pa Department Important any Injury 2059.		21. Signature of Funeral Service Licensee	22. Name end Address of Facility Francis J. Collins	Funoral He	ome Inc	
7	00240		1. Kevin Jutowski	500 University Blv	d.,W.,Silve	er Spring	,MD 20901
			23a. Part1. Enter the disease, or complications that caused the deeth. shock, or heert feilure. List only one cause on each line.	Do not enter the mode of dying, such as cardla	c or respiratory errest,		Approximate Interval Between
	Physician	Н	Landing Compared to the Compar	2		i It	Onset and Death
Ш	/Medicai Examiner		Immediate Cause (Final disease or condition reauting in death)	EN CEPHALO PA- s a consequence of): GASTROINTES	THY, MF	3881VE	DAYS
		<u>.</u>	Due to (or a	s a consequence of): GASTROINTES	TINALBLE	EDING-	
Т	bed hsrt	Examiner	END STAG	B LIVER DISPASS s a consequence of AMD GASTRES	2 WITH COAGU	LOPATHY	YRAGES.
	icete be executed physician and s the burial-transit	xar			BPHAGGAL VI	ANICALS	
92	Siclar Buri		that initiated events	ALCOHOLISM.			
68760,	artificete be executed ing physician and e es the burial-transit	edical	resulting In death) Last	s e consequence of):			
Box	8 0 8	M	d				
m	death ce	cla	Part II. Other algorities of against a section time to death but set with		ant Didaster		
0	the school	Physician/	Part II. Other algnificant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.			to the cause of death?
S, D	s that	by P			1 Ves	20 40 30 20	obably 4 ⊈Unknown
Ď	w requires that been signed I should be det				24a. Was an au		Vere autopsy findings
Record	es bee	Completed			performed	C	veileble prior to completion of cause of death?
	m	E			1 ☐ Yes	/	☐ Yes 2☐ No
Viia	ician: The certificate irector, pag	BeC	25. Was case referred to medical	26 Place of De	eath (Check only one)	243110	0.169 50.140
	Physician: this certific ral director,	0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER	Other	Home 5 Realdence	8 DOther (Spec	oifu)
of	F F is	D: T	27. Manner of Death 28a. Dete of Injury 28	Bb. Time of 28c. Injury at	28d. Describe how in		",,
0	Attending Firdeath. Cotor: After by the funer	atio	1 Natural 5 ☐ Pending (Month, Dey Year) 2 ☐ Accident investigation	Injury Work? M 1 Yes 2 No			
Division	or Attendi efter death. Director: A i in by the fu	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, office	28f. Location (Street City or Town, Str	and Number or Ru	ral Route Number,
	al or A s effer M Direct	Certification:	4 Homicide building, etc. (Specify)		City of Town, Si	6(6)	
	To the Hospital or Attend within 24 hours effer deatl To the Funeral Director: completely filled in by the	edicai	29a. Certifier (Check only (Ch	dge, death occurred at the time, date and place	e, and due to the cause	(s) and menner as	steted.
	To the Ho within 24 To the Fu complete		one) and manner stated.				
	To the within To the comple	Σ	29b. Signeture end title of certifier	29c. License number	29d. I	Date signed (Month	, Day, Year)
				- 12459	5	5,4.	47
	6		30. Neme and address of person who completed cause of death (Item 23	3e) (Type, Print) MD 371	5-RAOD	@ 18LA	ND AVE
	2			MOUN MOUN	IT RAINI	en, M	0,20712
	Sta Registr		31. Date filed (Month, Dey, Year) 32. Registrar's Signature MAR 0 5 1997	dson-Randelly			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08369 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Yeer March 3, Miguel Angel Santos 1997 7:00 AM /Medicai 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner 4c. County of Deeth 11508 Idlewood Road Silver Spring Montgomery If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Dey, 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country)
 CUDa **Funerai** 1**X** M 2□ F Months 431-45-0634 35 Director December 26, 1961 Usuel Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-1 shor the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20906 11508 Idlewood Road Funerai Cuba 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Yeer or Dates: 11 Marital Status Was Decadent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ¥ Yes 2 □ No p Specify: 3 Widowed 4 Divorced Cuba White Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygisna. Elementery/Secondery (0-12) College (1-4or 5+) contracting company 12 carpenter 17. Fether's Neme (First, Middle, Lest) Pages 1 and 2 should be till Iment of Health and Mental H tant: If tem 27 is marked off 18. Mother's Name (First, Middle, Meiden Surname) Be unavailable Amalia Matilde de la Caridad Navarro 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health as Important: If item 27 is any injury or other trau 5804 Tudor Lane, Rockville, Maryland 20852 Maria Corina Hernandez 20b. Pleca of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 3-4-97 Beltsville, Maryland Chesapeake Crematory 21. Signeture of Funerei Service Licensee 22. Name end Address of Fecility Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, MD 20910 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medicai Immediate Cause (Final Upper GI Hemorrhage 12 weeks diseese or condition resulting In deeth) **Examiner** Due to (or es e consequenca of): Examiner Esophageal varices and bleeding disorder months or Attending Physician: The law requires that the death certificate be executed after death. Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): and Division of Vital Records, P.O. Box 68760. Chronic hepatitis and cirrhosis vears Physician/Medicai Due to (or es e consequence of): Chronic hepatitis B and C infection years Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? s been signed by to should be detach 1 Tes 2 No 3 Probably 4 Unknown HIV/AIDS by Completed 24b. Were autopsy findings 24e. Wes en eutopsy performed? Transient but severe diabetes eveileble prior to completion of cause of deeth? certificate 2 No 1 ☐ Yes 2 XNo 1 ☐ Yes Herpes Simplex - chronic 25. Wes case referred to medical exeminer?
1 \(\text{Yes} \) Yes 2\(\text{No} \) Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 2 Other: 4 Nursing Home 5 X Residence 6 Other (Specify) this 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred Affer 5 Pending investigation 1 Neturel To the Hospital or Attendir within 24 hours after death. To the Funeral Director: All completely filled in by the fu 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stefe) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

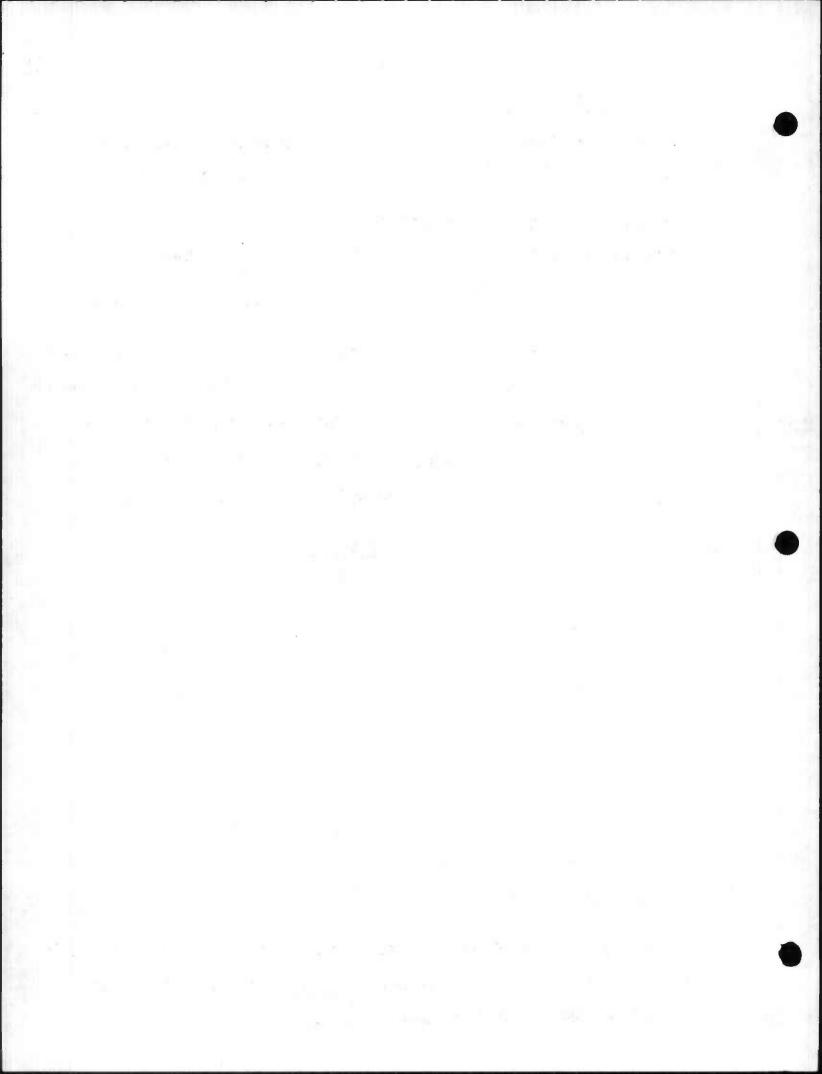
2 Medical Exeminer: On the bests of exemination end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner steted. Medical 29a. Certifier (Check only one) 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Dev. Year) Kathaline Wold many, Wor 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

3 State Registrar

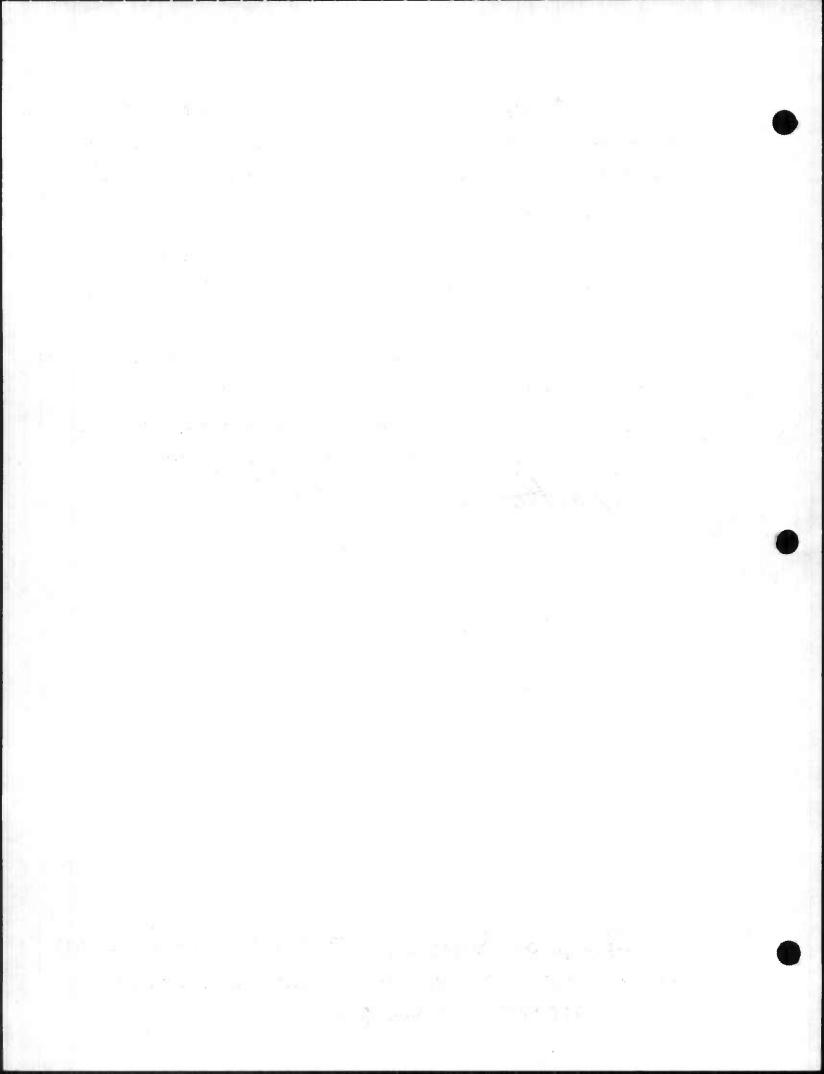
31. Dete filed (Month, Day, Yeer) MAR 0 5 1**99**7

32. Registrer's Signeture Lika Davidson

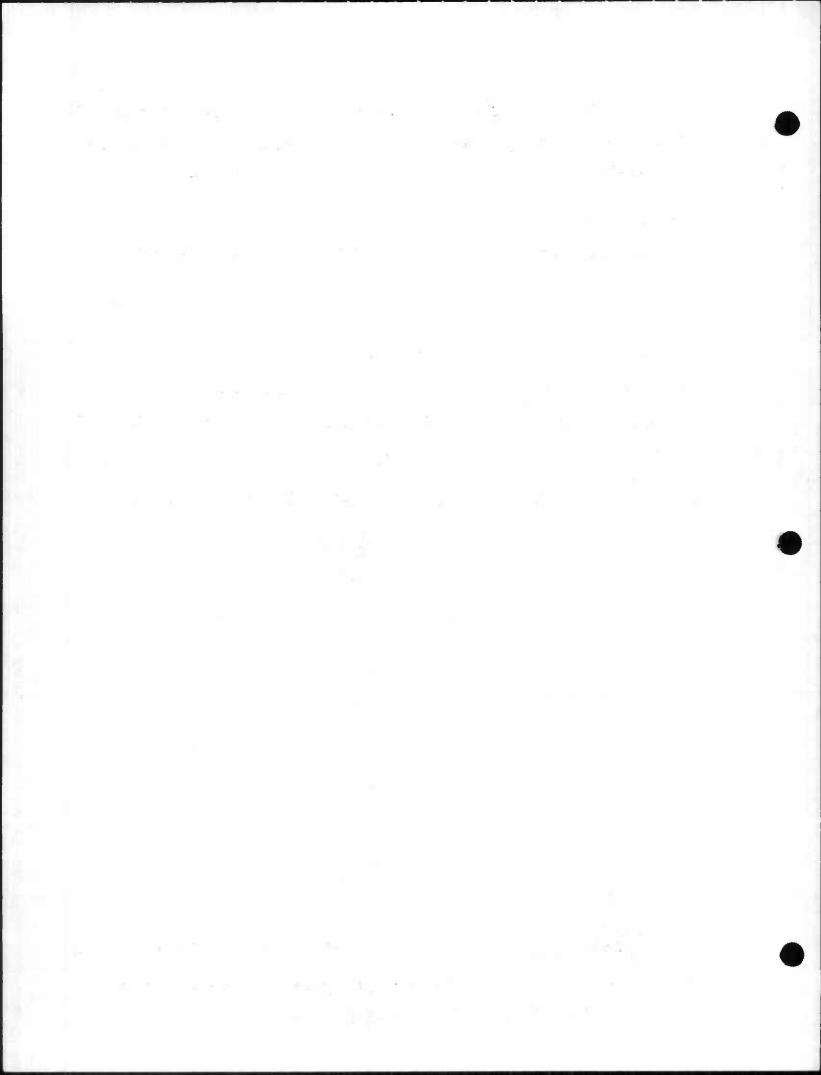
Katharine Waldmann, M.D., 2000 Dennis Avenue, Silver Spring, Maryland



		1. Decedent's Neme (First, Mid	ldie, Last)							2. Date of D			3. Time of Death
ysiciar Vedica	_	Fermino	Jos	eph		Spence	r			Februa	ary 26	, 1997	10:00 a.m
amine	er	4e. Fecility Neme (If not instituti			r)			4b. Ci	ty, Town, or L	ocation of Dee	oth 4c. Co	ounty of Deeth	
	щ	8333 Marketre	-				Milester			y Villa		ontgom	
eral ctor		5. Social Security Number 021.14.9469 Usuel Residence of Decedent	6. Sex	2 F	72	:. (ast birthdey) Yrs.	If Under 1 Y Months D		Inder 24 Hrs. ours Min.	8. Dete of B (Month, D Feb. 6,	irth Dey, Year) 1925		pplece (State or Foreintry) achusetts
18		10e. State 10b. Count	ty		10c. C	ity, Town or Lo	ocation						10d. Inside City Limit
the di	9	Maryland Mont	gomery		Mon	ntgomer	y Villa	age					1∑ Yes 2□N
e not	Director	10e. Street and Number					10f. Zip Co	de			10g. Citize	n of Whet Cou	untry?
4		333 Marketree	Circle				20879)			U.S.A		
Fire must	ne.	11. Marital Status	12. W	/es Deceden	t Ever in U	J,S. 13.	Was Decedent If Yes, specify	of Hispan	ic Origin? (Sp	ecify Yes or N	lo- 14	. Race - Ameri Bleck, White	
F 5	2	1 ☐ Never Married XX Ma 3 ☐ Widowed 4 ☐ Divorca	arried 1	∭XYes 2 ☐ Yes, Give eer or Dates	No WW		1□ Yes 2□		ecify:	11041, 010.,		pecify:	White
rt, the Medical	ered	15. Decede (Specify only high	ent's Education	n pieted)		16e. Deced	dent's Usuei Od kind of work do DO NOT use re	cupation	most of work	ina	16b. Kind	of Business/Ir	ndustry
the Me	Š.	Elementary/Secondery (0-12)	C	ollege (1-4or	r 5+)								
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any injury or other tr once.		Alice Spencer 20e. Method of Disposition			20b.	Plece of Dispo	Marketi esition (Name of matory or other	ee C	ircle	Montgor Dete	nery V	illage . tion - City or T	Md. 20879
y or		1 X Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (rel from Stete	8		natory or other Cemeter		3	/4/97		edford	
info	1	21. Signature of Furieral Service	-	9 —	DC.		2. Neme end Ad	-	4				
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lan İ		23a Part Enler the disease Annual Part Feliume. Vis				th. Do not ente					errest,	-	Approximete Intervel Between Onset end Death
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an	1. Decedent's Name (First, Middle, Las	t)				2. Date of Do Month	eath Day	3. Time of Death
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er								
=4				# Hinder 1 Ve				gomery
	086-12-3023		92			April	6, 1904	9. Birthplace (State or Fore Country) New York
-	10a. State 10b. County		10c. City, Tow	m or Location				10d. Inside City Llm
lor	Maryland Montgome	rv						1 ☐ Yes 2 ☐XI
rec	10e. Street and Number	3					10a. Citizen of V	Vhat Country?
rai D							United S	
þ	11. Maritel Status 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Yeer or Dates:	ever in U,S.			Specity Yes or No into Rican, etc.)	o- 14. Race Blac Specify	a - American Indian, k, White, etc. : : White
eted	15. Decedent's Edi	ucation de completed)	16a	Decedent's Usual Occ	supation	orkina	16b. Kind of Bu	
ошрі	Elementary/Secondary (0-12)		+)		ired)	OIKHIG	Bank	
	17. Fether's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle		e)
ToB	Waldemar Straluc	ke			Lisette	Kette	r	
		ype, Print)						
			_		eet, NW #	E, Wash	ington, [OC 20036
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	cemete	ry, crematory or other p		Date		City or Town, Stete
			Chesa	apeake Crem	atory	2-28-97	Beltsv.	ille, Marylar
	21. Signature of Euneral Service Licans	2/ R		Rapp Fune	ral Serv	ices, P.	Α.	0.0010
T	23a. Part1. Enter the disease, or comp	licetions that caused	the death. Do	not enter the mode of d	ying, such as cardio	ac or respiratory a	pring, Mi arrest,	Approximate
	Shock, of fleat failule. List only o	ne cause on each line	в.					triterval Between Onset and Deeth
	Immediate Cause (Final disease or condition	Pneumoni	a					3 days
	resulting in death)	a	Due to (or as e	consequenca ot):				
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Exar	Sequentiatly list conditions, if any, leading to immediate		Due to (or as a	consequenca of):				
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1 ASI	Part II. Other significant conditions cor	ntributing to death but	not resulting Ir	the underlying cause	given in Part I.	23b. Dld		tribute to the cause of dea
Dy P	dementia					1 🗆	Yes 2 No	3 Probably 4 □ Unkn
upiered						24a. Was	an autopsy ormed?	24b. Were autopsy finding available prior to completion of cause of deeth?
						10	Yes 2 No	1 ☐ Yes 2 💢 No
23	examiner?	doenital:				eath (Check only	one)	
2	TE TOS ZENTO	1 LI Inpatien		tpatient 3LI DOA	4X Xnursing	1		
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200	3 Suicide 6 Could not be	28e Place of Injur	v - At home fa			28f Location /	Street and Number	er or Rurel Route Number
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	Check only 2 Medical Exami	ner: On the basis of e	examination and	, deeth occurred at the d/or investigation, in my	time, date and place	e, end due to the urred at the time,	ceuse(s) end mar date end plece, a	nner as stated. nd due to the cause(s)
	29b. Signature and this plannifier	and manner stet	ed.		nse number			
0	MARINA				4032			(Month, Day, Year)
	V IIII			114			FORMILIA MI	
	The state of the s				4032		rebruary	27, 1997
	30. Name and address of person who co	empleted cause of dea						
Certification: 10 Me Completed by Prycipal Marina's Evamina's	To be Completed by Figure Investor Examiner	4a. Facility Name (If not institution, give Randolph Hills Nu 5. Social Security Number 0.86. So 0.86 - 12 - 3023 11	4a. Facility Name (If not institution, give street and number) Randolph Hills Nursing Cent S. Social Security Number 0 8 6 - 12 - 3 0 2 3 Usual Residence of Decedent 10a. State 10b. County Maryland Montgomery 10c. Street and Number 4011 Randolph Road 11. Maritel Status 12. Was Decedent Amel Forcas; 13 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 17. Fether's Name (First, Middle, Last) Waldemar Stralucke 19a. Informant's Name/Reletionship (Type, Print) Susan B. Fulton 20a. Method of Disposition 1 Burial 2 Octemation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licansee 23a. Partl. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line immediate devents resulting in death) 23a. Partl. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line immediate devents resulting in death) 25a. Partl. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line immediate devents resulting in death) 25a. Partl. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line immediate devents resulting in death) 25a. Partl. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line immediate devents resulting in death) 25a. Partl. Enter the disease, or complications that caused shock or heart failure. List only one cause on each line immediate devents of the determined of Line immediate devents of Line immediate devents of Line immediate devents of Line immediate devents of Line immediate devents of Line immediate devents of Line immediate devents of Line immediate devents of Line immediate devents of Line immediate devents of Line immediate devents of Line immediate devents of Line immediate devents of Line immediate devents of Line immediat	4a. Facility Name (if not institution, give street and number) Randolph Hills Nursing Center 5. Social Security Number 0.86-12-3023 Usual Residence of Decedent 10a. State 10b. County Maryland Montgomery 10c. Street and Number 4011 Randolph Road 11. Maritel Status 11 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specity only inglest grade completed) Elementary/Secondary (0-12) 10 College (1-4or 5+) 10 Susan B. Fulton 20a. Method of Disposition 1 Burial 2 Octemation 3 Removal from State 4 Donation 5 Other (Specity) 21. Signature of Eueral Service Licansee 22. Signature of Eueral Service Licansee 23. Part I. Enter the disease, or complications that caused the death. Doing that inflated events in any, leading to immediate cause. Enter Underlying that inflated events resulting in death) Part II. Other significant conditions contributing to death but not resulting in death) Part II. Other significant conditions contributing to death but not resulting in death) 25. Was case referred to medical examiner? 26. Due to (or as a condition of the conditions contributing to death but not resulting in death) 27. Manner of Death (Month, Dely Year) 28. Due to (or as a condition of the death of the conditions of the co	Randolph Hills Nursing Center S. Social Security Number (10. County Number 0.86 - 12 - 30.23	Randol ph Hills Nursing Center Social Security Number Social Secur	Randolph Hills Nursing Center Randolph Hills Nursing Center Social Security Number 0.86 - 12 - 30.2 3 1 M AX 9 (In yrs. last birmday) Meaton 108. State 1 100. County Months	Randolph Hills Nursing Center S. Social Searily Number 6. Sex 7. App (in yrs. last brindsy) 10 Under 1 Veet 10 Under 2 Et His. 5. Dear of Burt 10 Under 1 Veet 10 Under 2 Et His. 5. Dear of Burt 10 Under 1 Veet 10 Under 2 Et His. 5. Dear of Burt 10 Under 1 Veet 10 Under 2 Et His. 5. Dear of Burt 10 Under 1 Veet 10 Under 2 Et His. 5. Dear of Burt 10 Under 1 Veet 10 Under 2 Et His. 5. Dear of Burt 10 Under 1 Veet 10 Under 2 Et His. 5. Dear of Burt 10 Under 1 Veet 10 Under 2 Et His. 5. Dear of Burt 10 Under 1 Veet 10 Under 2 Et His. 5. Dear of Burt 10 Under 1 Veet 10 Under 2 Et His. 5. Dear of Burt 10 Under 1 Veet 10 Under

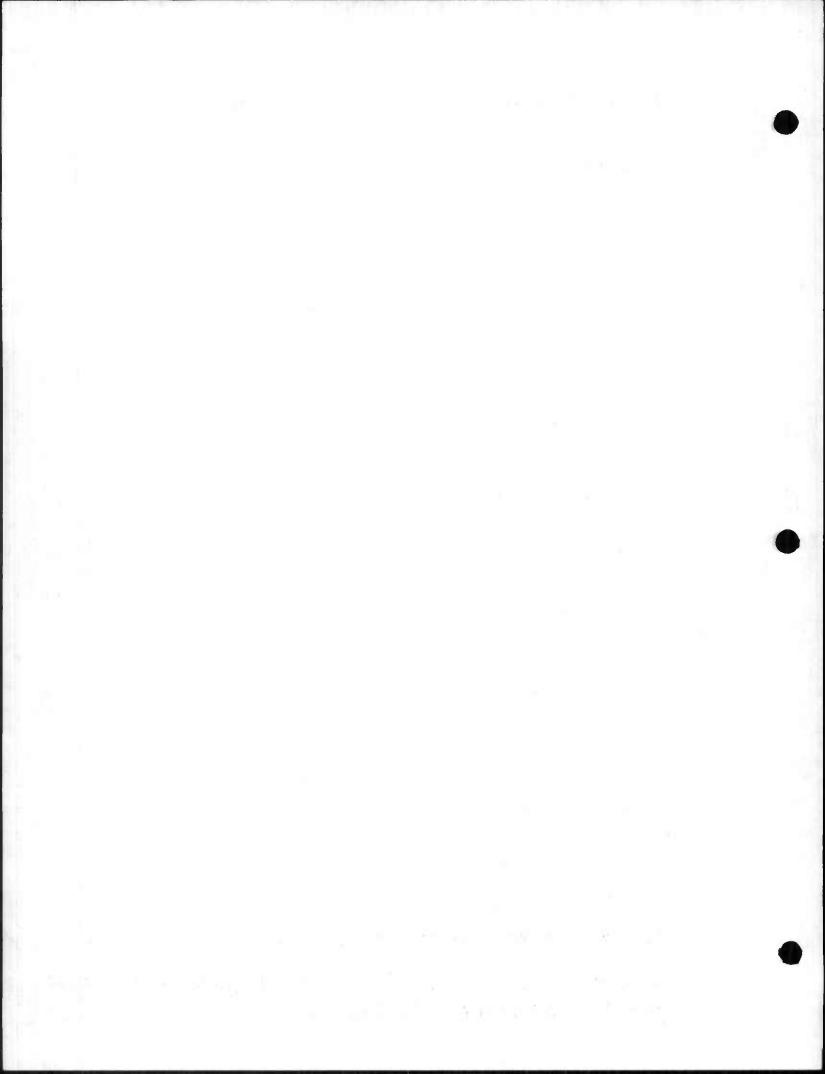


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	Discourse 1		1. Decedent's Nama (First, Middle, L					. Date of Death			na of Death
	Physici /Medi		Thomas	Deb	ruyNe	Stearr	15	Jarch C	5 199	7 09.	:05 Am
	Examir		4a. Facility Name (If not institution, g	ive street and numb	per)		4b. City, Town, or Loca		4c. County of	of Death	
A .	Funeral Director		SHADY GROVE ADS 5. Social Security Number 6. 363-44-1937 Usual Residence of Decedant		Aga (In yrs. last birt	thday) If Under 1 Year Months Days	Hours Min.	E. Data of Birth (Month, Day,) ay 19,	(ear)	IIGOMERY 9. Birthplace (Si Country) Michig	
	B		10a. State 10b. County		10c. City, Town	n or Location				10d. Insl	da City Limits
	isr death with the Marylar items 23a or 23a-f show iner must be notified at	ō	Md. Montgo	omery	Gaithe	rsburg					Yas 2 No
	138 notifi	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of W	hat Country?	
	38 or		9400 Gentle Circ	le		2087	9		United	5	
	doat ma 2	Funeral	11. Marital Status	12. Was Decede	ent Ever in U,S.	13. Was Decedent of H	lispanic Origin? (Specia	fv Yes or No-		- Amarican India	ın,
020	ours at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 X Yas 2 If Yes, Give Yaar or Date	□No Air Force	If Yas, specify Cube	an, Mexican, Puarto Ric Specify:	can, atc.)		White, atc.	
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and	2 d d 2	Be o	17. Father's Name (First, Middle, Las Thomas Suddard St	tearns			18. Mother's Name (I Leonora I)	
Ž	d 2 should b th and Menta 7 is merked traumatic e	5	19a. Informant's Name/Relationship	(Type Print)	19b	Mailing Address (Street	and Number or Bural f	Boute Number (City or Town S	State 7in Code)	
Š	od 2 sh lith and 27 is m r traum		Thomas S. Stearns			110 Skipjac					
Baltimore,	Pages 1 a ent of Hea it: if Item y or othe		20a. Method of Disposition 1 Burial 2 Cramation 3 4 Donation 5 Other (Spec	☐Removal from Sta	20b. Place of cematar	Disposition (Name of y, crematory or other place olitan Crematory	ce)		Oc. Location - C	City or Town, Sta	ta
Balti	peimit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Jolury or other tra 2009.		21. Signature of Funeral Service Lice		. 0 0.	22. Name and Addra	ss of Facility DeVo	ol Funei ive Gait	ral Hom thersbu	e rg, Md.	20877
		\vdash	23a, Part1, Enter the disease, or cor	nolications that cau	sed the death. Do n					Approx	
	Physician /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final		ung C		ig, soon as cardiac or i	espiratory arres		Interva Onsat	l Between and Death
	Examiner		disease or condition resulting in death)	a	J					Mo	NTHS
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j	8 + ± ±	ysic	Part II. Other algnificant conditions	contributing to deat	h but not rasulting in	tha underlying causa giv	en in Part i.	23b. Dld tob	acco uae cont	tribute to the ca	use of death?
7		Y P	Coronary	Arter	1 Dis	ease		1 TYes	2□ No	3 Probably	4 Unknown
Records,	w requires that been signed should be det	Completed by	J		J			24a. Was an performe	autopsy ed?	24b. Were auto available p completion of death?	rior to
T W	The law ate hes t page 2 s	отр						1 ☐ Yes	2 0 No	1 ☐ Yes	200 No
VITA		0	25. Was case referred to medical				26. Place of Death (240110
		To B	examiner? 1 Yes 2 No	Hospital:	atient 2 ER/Out	tpatient 3 DOA Oth				r (Specify)	
ion or	After After fune		27. Mann of of Death 1 DNatural 5 Pending 2 Accident Investigation	28a. Date of I (Month,	njury 28b. T	njury Wor		d. Describe how			
DIVISION	s after de N Directo ed in by th	Certification:	3 Suicide 6 Could not 4 Homicide determined	286. Place of	Injury - At homa, far, etc. (Specify)	rm, street, factory, office	281	f. Location (Stre City or Town,	et and Numbe State)	r or Rural Route	Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edicai	29a. Certifier (Check only one) 11D Certifying P. 2 Medical Exa	hyaician: To the be miner: On the basis and manner	s of examination and	death occurred at tha tire for investigation, in my o	ne, date and place, and plnion, death occurred	d due to tha cau at the time, dat	ise(s) and man e and place, ar	ner as stated. nd due to the car	use(s)
		Σ	29b. Signature and title of certifier		z m	O 29c. Licens	e number		d. Date signed	(Month, Day, Ye	ar)
	20		30. Name and address of person who	101 OHM.	ACDONALD	Type, Print) Rd. GAITHE					
	Sta	-11	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signature	10 Jan					
DIV	Registr		MAR 0 6	199/	June varias	ol-Nathana					

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-						Ce	rtificate d	of L	Death		Reg. N	No.			
в	Dhuala		1. Decedent's Name (First, Mid	dia, Last)						2. Date of Month		Day	Vons	3. Tima	a of Death
	Physic /Medi		Abigail	Sutton						Febru	ary	28, 1	1997	4:4	6 PM
	Examir		4a. Facility Name (If not instituti	ion, giva straat and n	um <i>bar)</i>			4	b. City, Town, o	or Location of De		4c. County	of Death		
1			Holy Cross	Hospital				5	Silver S	Spring		Monto	gomery	/	
п	Funerai		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 You Months Da	ear ays	If Under 24 H Hours _M		Birth Day, Yas	ar)	9. Birthpla	ace (Star	ta or Foreign
	Director		None	1□ M 21X F		Yrs.	WOILING	495	1.			, 1997	Ma	ryla	and
	p a		Usuel Residence of Decedent 10a. State 10b. Count	h	10- 08	y, Town or Lo	antina						- 1		
	anylar show ad at	_		•									10		City Limits es 2 □ No
	2 24	SC C	-	tgomery	Ga	ithers								, ,	es Z No
	with the Marylar s or 28a-f show be notified at	Director	10e. Street and Number	5			10f. Zip Cod						Vhat Countr	-	
	death with the Maryland ris 23s or 28s-f show crisst be notified at	ig .	660 West Side					087				-	State		
		Funerai	11. Marital Status	12. Was Dec	cedent Ever in U forces? 2 No	,S. 13.	Was Decedent If Yes, specify (of Hi	spanic Origin? n, Mexicen, Pu	(Specify Yes or erto Ricen, etc.)	No-		e - Americe k, White, e		
20	# 5 5	by F	1 X Never Married 2 Ma 3 Widowed 4 Divorce	If Yes, G	ive		1 💢 Yes 2 □	No	Specify: G	uatemal	a	Specify	Bla	ck	
Maryland 21215-0020	natural,	Pa		ent's Education	Dates:	16a Dago	dant's House Or					Vind of D			
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D	祖子を見		17. Father's Nama (First, Middle	a, Last)			NOTIC		18. Mothar's N	lame (First, Mide	dla, Maidi			-	
a	Mental Mental rhed o	o Be	Raymond Su	tton					Viole	eta Ba	raho	na			
ž	d 2 should b h and Menta 7 is marked traumatic en	-	19a. Informant's Nama/Ralation			19b. Mailii	ng Addrass (St	reat a		Rural Routa Nur			Stata Zin (Code)	
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, E	Pages nent of in net: If its my or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State .		ke Crem			3-6-97	Ro	ltcvi	11e,	Mana	land
Baltimore,			21. Signature of Funeral Service		CII		2. Name and Ad			3-0-37	De	1 65 7 1	iie,	riary	ranu
Ba	permit. Departm Importa any Infu		I	000	7	Ra	pp Fune	era	1 Serv	ices, P.	Α.				
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л			23a. Part1. Enter the diseese, of shock, or heart failure. Lis	st only one cause on	each line.	n. Do not em	er the mode of	dying	g, such as card	iac or respirator	y arrest,			Approxin Interval E	
	Physician /Medicai		Immediate Cause (Final		0	(1	_	Ā						4
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of	F F F	Ë	27. Mapner of Death	28a. Data	of Injury	28b. Tima o		njury		28d. Dascrit	-				
Division	Attending For death. Sector: After by the funer	atio	10 Netural 5 ☐ Pend 2 ☐ Accident Invest	ing (Mor tigation	nth, Day Year)	Injury			:7 ∕es 2 □ No	a	1/A-				
VIS	Attend r death actor: , by the	Hice	3 Suicide 5 □ Could	minert 28a. Plac	e of Injury - At ho	on a, farm, str	eet, factory, off	ica		28f. Location			er or Rural i	Routa N	um <i>ber</i> ,
Ö	o effe	Certification	4 Homicide	build	ling, etc. (Spacif	y)	1	A	_	City or	Town, Ste	11/1			
	pspit hour mera ly fille		29a. Certifier Mc Certify	ing Phyaiclan: To the	e bast of my kno	wiedge, daath	occurrad at th	e tim	e, date and pla	ce, and due to ti	ne cause	(s) and ma	nnar as sta	ted.	
	To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: Al completely filled in by the fu	edical	(Check only 21 Medica	Examinar: On the band mar	pasis of axamina nnerstated.	tion and/or in	estigation, in n	ny op	inion, daath oc	curred at the tim	e, date a	nd place, a	and due to t	he ceus	a(s)
	To the Tour	≥	290. Signature and title of could	or \	1		29q. Lic	ense	number		29d. D	ete signed	(Month, D	ay, Yaar)
			· conject	in de	work	2	MI		140	502		314	97		
			30. Name and address of person	n who completed cau	sa of death (Item	23a) (Type,	Print)		000	/	A	-	2 /		4
			Angela).	Thomps	on/M	.1).	501	V	·trea	lenck	And	2. 6	nyte	413	bur
	Sta	te	31. Data filad (Month, Day, Yaar		Registrar's Signa								n	w	
	Registr	ar	MAR	0 7 1997	julia	Davidson	Mandall.								
-	MU 40 Day 600				U		2%								

_/Medical	_	-	ville				th City Taux	Februa			10:30A.
Examiner	r	4a. Fecility Neme (If not institution, given 1414 Oak Bluff	•			4	Edgewa	or Location of Deeth ter		y of Deeth Arunde	1
Funeral Director	1	5. Social Security Number 220-58-7012 Usuel Residence of Decedent	Sex 1□M XX F	e (In yrs. last 53	birthday) If Under Months	r 1 Year Deys	If Under 24 H Hours M	in. 8. Dete of Birt (Month, De	n y. Year) 1943	9. Birthpleo Country, Virgi	e (State or Fore nia
f show		10a. Stete 10b. County Maryland Anne Ar	undel		own or Location						Inside City Lin
23a or 28a-f show ust be notified at rai Director		10e. Street end Number 1414 Oak Bluff	Road		10f, Zip	Code 21	037		10g. Citizen of United		?
al, or items Examiner in	2	11. Maritel Status 1 Never Merried 3 Widowed 4 Divorced	12. Wes Decedent E Armed Forces? 1 ☐ Yes 2 Avi If Yes, Give Yeer or Detes:	Ever In U,S.	13. Wes Dece if Yes, spe- 1 Yes		ispenic Origin? in, Mexicen, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	14. Rad Ble Specif	ce - Americen ick, White, etc. fy: Whit	
Important: if item 27 is marked other than "natural; any injury or other traumatic event, trailed Exagnes. To Be Completed by	paraidiuo	15. Decedent's E (Specify only highest gra Elementery/Secondary (0-12)	ducetion ade completed) College (1-4or 5-	+)	6e. Decedent's Usua (Give kind of wo life. DO NOT us Secretary	ei Occup ork done o se retired	etion during most of v	vorking	16b. Kind of 8	Business/Indus	try
atic event	0 000	17. Fether's Neme (First, Middle, Last, Clarence	LeMari	r			18. Mother's N	eme (First, Middle, M.		ne)	100
27 Is mar traumat		19e. Informent's Neme/Reletionship (Forest K. Savill) 1	9b. Meiling Address Same a			Rural Route Numbe	er, City or Town,	, Stete, Zip Co	ode)
y or other		20e. Method of Disposition XXX Burial 2		ceme	of Disposition (Ner stery, cremetory or d e Washing	other piec	e) Cemete	Dete ry 2/28/1	20c. Location		
Importar any Injur once.		21. Signal a of Funerel Service Licer	··	lt-	22. Name an Dona I	Addres	s of Fecility Borgwa	rdt Funer Road Bel	al Home	P.A.	
		resulting in death)				VIV					
iding physician and ise as the burletransit		Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in deeth) Lest	c	Oue to (or es	e consequence of):	28 15	IN	YHK BK	PAM		2 men
_ ~		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	Oue to (or es	e consequence of):				obacco uas co		
igned by the attending be detached for use es by Physician/Me	The state of the s	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest	c	Oue to (or es	e consequence of):			23b. Did t	obacco use co	3 Probabl	ly 4 Unkn
has been signed by the attending ge 2 should be detached for use es mpleted by Physician/Me	The state of the s	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest	c	Oue to (or es	e consequence of):			23b. Did t	obacco use co	3 Probable 24b. Were a eveilet	autopsy finding ble prior to etion of ceuse
ate has been signed by the attending page 2 should be detached for use expand by the attended for use except by the signal of the state	The second secon	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Pert ii. Other significant conditions of the conditions of the cause (Disease or injury that initiated events resulting in death) Lest	c	Oue to (or es	e consequence of):		en in Pert i.	23b. Did t 1 1 1	obacco use co res 2 No en eutopsy med?	3 Probable 24b. Were a eveilet comple	4 Unknown 4 Unkn
his certificate has been signed by the attending al director, page 2 should be detached for use ea. To Be Completed by Physician/Me	The second secon	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Pert ii. Other eignificant conditions of exeminer? 1 Yes 2 No	c	Due to (or es	e consequence of): e consequence of): g in the underlying o	euse give	en in Pert i. 26. Piece of □	23b. Did t 1 1 1 24a. Wes operfor 1 1 1 Y eeth (Check only or	obacco use co res 22 No an eutopsy med? res 2 No ne) ence 6 Oth	3 Probable 24b. Were eveilet comple of dee 1 Year (Specify)	4 Unkr autopsy finding ble prior to etion of ceuse th?
ther this certificate has been signed by the attending uneral director, page 2 should be detached for use e.	The second secon	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest 25. Wes case referred to medical exeminer? 1	d	Due to (or es of the total transfer of the t	e consequence of): e consequence of): g in the underlying o	OA Other	en in Pert i. 26. Piece of □	23b. Did to 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	obacco use co res 22 No en eutopsy med? res 2 No ence 6 Oth ow injury occur	3 Probable 24b. Were evelete completed of deelers and the completed of the complete of the co	autopsy finding ole prior to etion of ceuse th?
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his certificate has been signed by the attending al director, page 2 should be detached for use ea. To Be Completed by Physician/Me		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest 25. Wes case referred to medical exeminer? 1	d	oue to (or es out to the control of	e consequence of): e consequence of): e consequence of): g in the underlying continuity of the underly	OA Other	26. Piece of D 36. Piece of D 37. 4 Nursing 4 Nursing 4 Y 4 Y 4 Y 4 Y 4 O 4 O 4 O 4 O	23b. Did to 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	obacco use co	24b. Were evelet completed and due to the	autopsy finding ole prior to etion of ceuse th? se 200 No bute Number, d. eceuse(s)



State of Maryland / Department of Health and Mental Hygiene 97

08375

								Cer	tificate o	f De	eath		Re	eg. No.	7 1	0 (0010
Ph	ıysici	an	1. Decedent's Neme (First,	Middle, La	st)		2						2. Dete of Deet Month	h Dey	Yeer	3. Tir	me of Death
	Medic		Sulayman	Sow									February	y 22 , 19	97	8:	59 AM
Ex	camin	er	4e. Fecility Neme (If not inst			mber)				4b.	City, To	wn, or Lo	ocation of Deeth	4c. Count	y of Deeth		
			Holy Cross						Midada d Ma			^ Spi		Montg	omery	1	
100 100	neral		5. Social Security Number	6. 8	Sex IDXM 2□ F	7. Age (Ir	n yrs. last birt	hday) . Yrs.	If Under 1 Ye Months Dey		Hours	Min.	(Month, Dev.	Year)	Cour	itry)	tate or Foreign
	ctor		NONE Usuet Residence of Decede	ent								40	February	22, 199	Mar	ylar	nd
ylend	H		10e. Stete 10b. C	ounty		10	c. City, Towr	or Loc	cation						1	0d. Insi	ide City Limits
May May	Delic	tor	Maryland Mor	ntgom	erv	5	Silver	Spi	rina							1 🗆	Yes 2 No
th th	9	Director	10e. Street end Number						10f. Zip Code	9			10	Og. Citizen of	Whet Cour	itry?	
th wi	4		8600 16th Str	reet					2091	0				United	Stat	es	
1215-0020 within 72 hours efter death with the Maryland ene. then "natural", or items 23s or 28s-f show	Examiner must be nothing at	Funeral	11. Maritel Stetus		12. Wes Dec		r in U,S.	13. V	Vas Decedent of Yes, specify C	of Hispo	enic Orig	gin? (Spe	ecify Yes or No-		ce - Americ		en,
20 sefte	di di		1 Never Merried 2		1 ☐ Yes If Yes, Gir	2 XVo			☐Yes 2X☐N		Specify:	,	, , , , , , , , , , , , , , , , , , , ,	Specil	fu:		
15-002 72 hours "natural",	E E	d by	3 Widowed 4 Div		Year or D	ates:									Bla		
15- n 72	the Medical	Completed	(Specify only I		ducation de com <i>pleted)</i>		16e.	(Give I	ent's Usuel Occ kind of work dor OO NOT use ret	ne duri	on <i>ing</i> most	of worki	ing	16b. Kind of B	ustness/Ind	Justry	
filed within Hygiene.	2	E C	Elementery/Secondary (0 NONE	-12)	Coltege (1-4or 5+)		me. L	none	iieu)				non	_		
offled 2	event, 1	ပို	17. Fether's Neme (First, Mi	iddle, Last)	1				none	18	8. Mothe	r's Name	(First, Middle, N	non- faiden Sumer			
ylan Suld be Mental	2	To Be	Mamadou So	owe							Agie		owe		,		
Marylat 2 should b end Mente 1s marked	traumatic	-	19e. informent's Name/Rele		Type, Print)		19b.	Meilin	g Address (Stre	_			al Route Number,	City or Town	. Stete. Zip	Code)	
1 and 2 Health e			Agie Sowe						-				er Sprin			-	0910
Baltimore, Maryland 21215-0020 pernit. Peges 1 and 2 should be filed within 72 hours eft Depertment of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or	or other		20a. Method of Disposition				Ob. Piece of	Dispos	sition (Neme of atory or other p				- T	20c. Location		wn, Ste	ite
Pege Pege nt: If	ry or		1 ☐ Buriel 2 ☐ Creme 4 ☐ Donetion 5 ☐ Oth			State			Heaven	nacaj		13	-7-97	Silver	Snnii	na	MD
alt.	any injury once.		21. Signeture of Funerel Se	rvice Licer	isee		uu cc	22.	Neme end Add			у				19,_	טוין
m aae	# G		Cara	20	000			F	Rapp Fu	ner	al S	ervi	ices, P. Silver S	A.	MD	2001	10
	- 1	\neg	23e. Pert1. Enter the disees shock, or heart failure.	se, or com	plicetions thet o	eused the	death. Do n	ot ente	r the mode of d	lying, s	such es	cardiac o	or respiretory erre	pring,	MD	2091 Approx	timete el Between
Physic	cian	6	snock, or near failure.	LIST ONLY	one ceuse on a	acn line.										Onset	end Deeth
/Med	_		Immediete Ceuse (Finel diseese or condition		Pulm	onarv	/ Нурор	olas	sia						4	O m	inutes
Exami			resulting in deeth)		е	1 1 1	to (or es e c				v 4					0 111	i ii d cc s
N. D.	# 100	Examiner		_	_ Skel	etal	Dyspla	asia	a						4	0 m	inutes
X 58760, certificate be executed ding physicien end	-tren	хап	Sequentially list conditions, if eny, teeding to immediate ceuse. Enter Underlying		U	Due	to (or es e c	onsequ	uence of):								
68760, ificete be ex	punie		Ceuse (Disease or Injury	1	c	11											
Dhys	s the	edicai	thet initieted events resulting in deeth) Lest			Due	to (or es a co	onsequ	ence of):								
BOX to ath certif	98	3			d										j		
that the death c	for	Physician	Death Other design	41-1													
T.C. hat the de od by the	ache	hys	Pert tl. Other significant cor	naitions co	ontributing to de	eath but no	t resulting in	the un	derlying cause	given i	in Pert I.						use of death?
S, T	e det	by P											1 Ye	8 200 No	3 Prot	abiy	4 Unknown
requires that the death	d plnods												24e. Wes er		24b. We	re auto	psy findings
law requ	2 sho	ojet											perform	ed?	cor	npletion	or of ceuse
The lav	909	Completed											1 □XYe	s 2 No		Yes	2/0 No
VITAI IIclan: Th certificate		Bec	25. Wes cese referred to me	dical						26	6 Place	of Deeth	(Check only one			1105	461140
VISION OF VITA Attending Physician: ar death. actor: After this certific	direc	10	exeminer?		Hospitel: 1 📉	npatient	2 ER/Out	patient	3 DOA	When			ne 5 Reside		er /Specify	()	
0 5 5	rd .		27. Menner of Death		28a. Date of		28b. Ti		28c. In				28d. Describe ho				
eth.	he fu	atic	Z LI MODIOGIN	vestigetion		, Doy 100		july			2 🗆 N	lo					
Att de de de de de de de de de de de de de	6	Certification:		ould not be etermined	286. Piece	of Injury -	At home, fan	m, stre	et, fectory, offic	е		2	28f. Location (Str. City or Town,		oer or Rura	Route	Number,
Tales of the District	Pe .																
dosp 4 hou	ely ti	edicai	formery print 51 I Med	tifying Phylical Exam	sician: To the iner: On the ba	best of my	knowledge,	death	occurred et the	time, o	dete end	plece, e	end due to the can ed et the time, de	use(s) end ma	anner as st	ated.	160(s)
To the Hospital or Attending F within 24 hours efter deeth. To the Funeral Director: After	completely filled in by the funeral	_			end mann	ner steted.											
₽ ₹ ₽	8		29b. Signeture end title of ce	- /	0)			29c. Lice		176		29	d. Date signe	d (Month, L	Dey, Ye	ar)
			Mallho	-	card,	mi	0		D00!	505	22		F	ebruar	y 22,	199	97
			30. Neme and address of per														
	0.		Matthew Pic 31. Dete fited (Month, Day, Y			y Cro	SS Hos	spit	tal 1500) F	ores	t Gl	en Road	, Silve	r Sprin	ng, M	1 D
Rec	Stat gistra	•	BIA DO	997		egistrer's S											
DHMH 16 Re	107.35			33/	fund	Leuda	on By		,								
							_										

the time of the sa

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

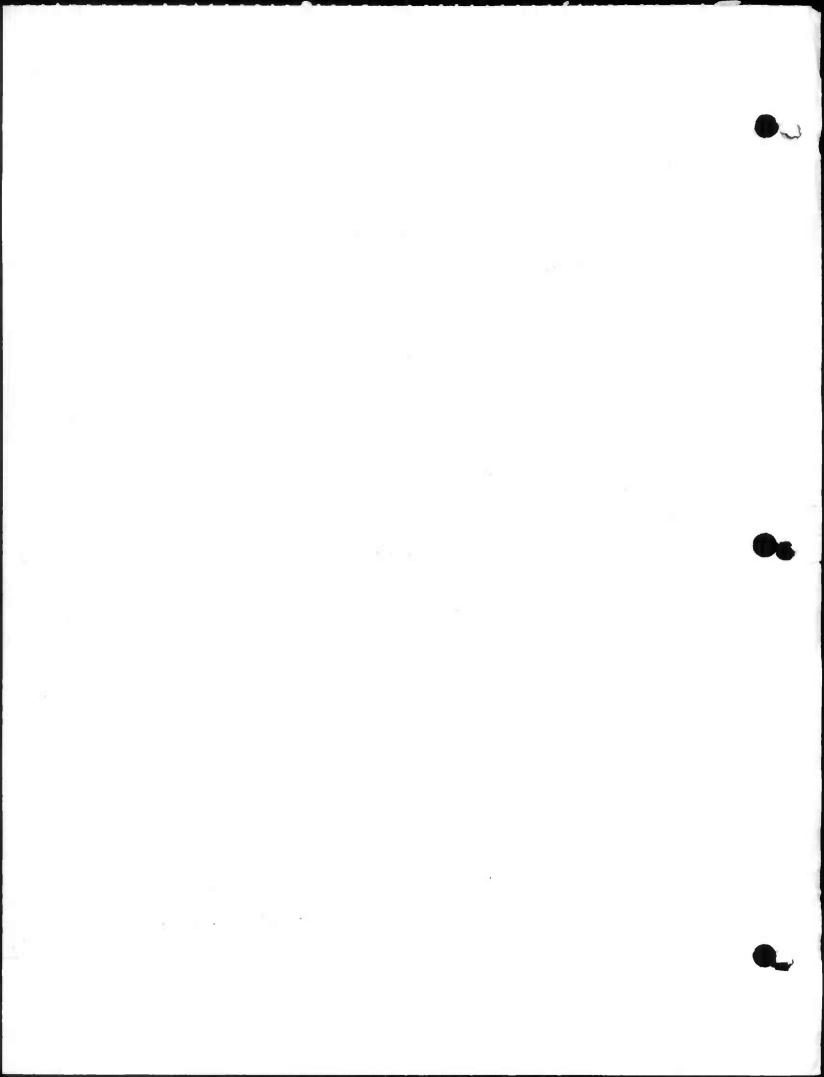
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within connected within connected for may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

		FOR	
1	_	STATE	
	_	REGISTRAR	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

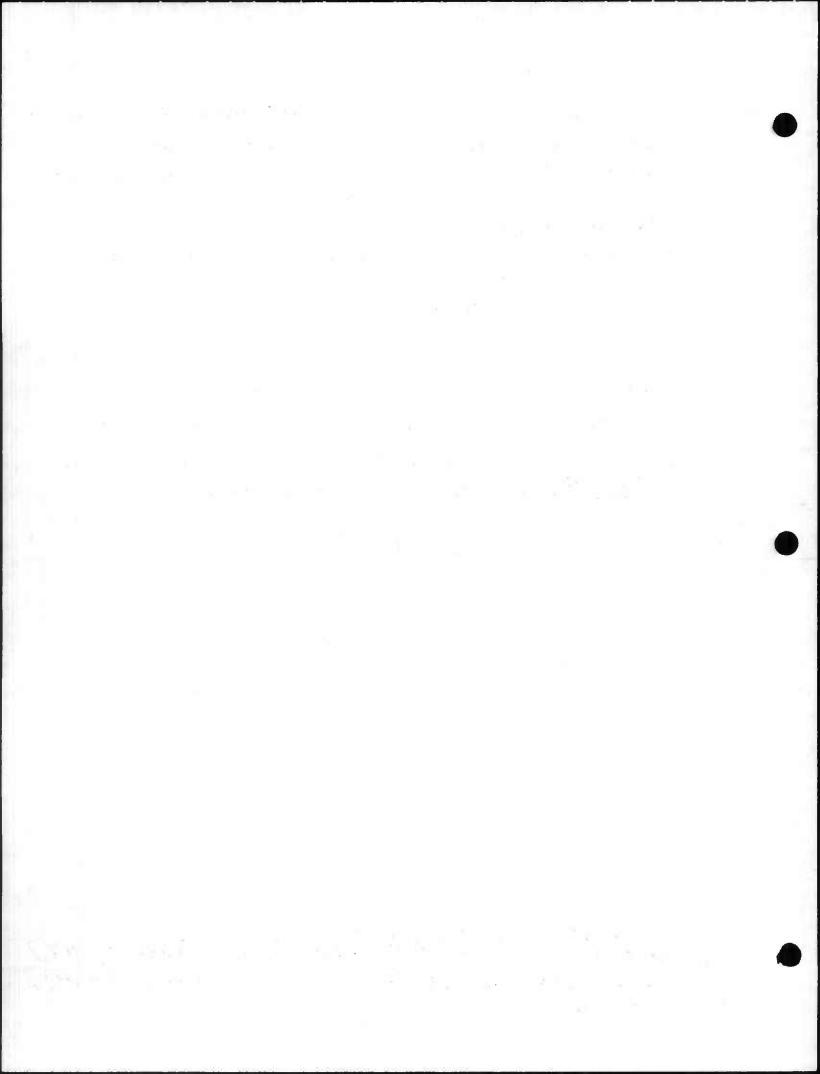
	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO).							
Ž.	1. DECEDENT'S NAME (First, Middle, Last)	2. DATE OF DEATH		3. TIME OF DEATH										
	LEAH SACHS					FEBRUARY 2	22. 1997							
Į.	4. SOCIAL SECURITY NUMBER		E (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	a. BIRT	THPLACE (State or Foreign						
	577-44-2385	1 M 2X F	64 YRS.	MONTHS DAYS	HOURS MIN.	2/14/1933		HINGTON, D.C.						
	9s. FACILITY NAME (If not institution, give str				OR LOCATION OF D		9c. COUNTY OF	DEATH						
DIRECTOR	HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY													
2	PRESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY													
SIR	MARYLAND MONTGO			KVILLE	TION			10d. INSIDE CITY LIMITS?						
	10e. STREET AND NUMBER			10	f. ZIP COOE		T 100 CITIZEN OF	1 YES 2 NO						
BY FUNERAL	6121 MONTROSE ROAL)			109. CITIZEN OF WHAT COUNTRY? 20852 UNITED STATES									
	11. MARITAL STATUS 1 Never Merried 2 Married 3 Nidowed 4 Divorced	12. WAS DECEDENT EVEI FORCES? 1 YE IF YES, GIVE WAR OR	S 2 ANO	It yes, s	CENDENT OF HISPA secify Cuban, Mexic 2 NO Speci	NIC ORIGIN? (Specify Yean, Puerto Rican, atc.) fy:	Bia	ACE — American Indian, Black, White, etc. Specify: WHITE						
6	15. DECEDENT'S EDUC (Specify only highest grade of	ATION	18a. DECEDENT'S	USUAL OCCUPATI	ON	16b. KIND OF BU	ISINESS/INDUSTRY							
Fi	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us		ost of working									
M M		1	HOMEM	AKER		OWN HO	OME							
BE COMPLETED	17. FATHER'S NAME (First, Middle, Last) EMMANUEL SACHS 18. MOTHER'S NAME (First, Middle, Meiden Surname) DOROTHY (UNKNOWN)													
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rural	Route Number, City or Tox	vn, Stete, Zip Code)							
٦	ARTHUR FABEL (GUAF	RDIAN)	μ4120	FLINT RO	OCK ROAD,	ROCKVILLI	E, MARYLA	AND 20853						
	20e. METHOD OF DISPOSITION 1 X Burial 2 Cremetion 3 Ramo		20b. PLACE AND DATE		ame of	DATE 20c. LC	OCATION — City or	Town, Stata						
- 1	4 Donation 5 Other (Specify)		CHESED SH	EL EMES		2/23 WAS	SHINGTON.	D.C.						
	22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, 1170 ROCKVILLE PIKE, ROCKVILLE, MD 2													
	23. PART I. Enter the diseases, or c	omplications that caus	ed the death. Do	not anter the me	da of dving, suc	th as cardiac or rean	JCKVILLE	Approximata						
ı	shock, Dr haert failure. L	lat only one cause on	aach lina.		, , , ,			Interval Between Onset and Death						
	iMMEDIATE CAUSE (Final disease or condition	PNE	MONI	TIC				_						
	resolding in death)	DUE TO (OR AS						3 WEEKS						
z		CERER DUE TO (OR AS	ROVASO	111 A	7	DISTAC	E	VEADE						
은	Sequentially list conditions, if any, leading to immediate	DUE TO (OR A	S A CONSEQUENCE O	F):		1001,3		141123						
CERTIFICATION	CAUSE (Disease or Injury	HYPER						YEARS						
#	that initiated events resulting in death) LAST	DUE TO (OR AS	S A CONSEQUENCE O	F):										
#	resulting in death) LAST													
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 24a. WAS AN AUTOPSY FINDINGS													
DICAL	MENINGION	1A. SEI	ZURE	DIS	ORTHE	PERFO	10.00	AVAILABLE PRIOR TO COMPLETION DF CAUSE						
						1 1 123	PENO	OF DEATH?						
2	DID TOBACCO USE CONTR	BUTE TO CAUSE	OF DEATH YE	S I NO I	UNCERTAI		- 1	1 YES 2 NO						
<u>\$</u>	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEA		JOINGERIA									
PHYSICIAN: ME	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/O	utpatient 3 DOA	OTHER:	fome 5 ☐ Reeldence 8 ☐ Other (Specify)									
美	27. MANNER OF DEATH	28e. DATE OF INJUR (Month, Day, Year	Y 28b, TIM	E OF 28c. IN.	URY AT	28d. DESCRIBE HOW								
ВУБ	1 Natural 5 Pending 2 Accident Investigation	(MOINI, Day, 184)	7		YES 2 NO									
	3 Suicide 8 Could not be	28e. PLACE OF INJU	•	281. LOCATION (Street and Number or Rural Route Number,										
	4 Homicide determined building, atc. (Specify)													
COMPLETED	29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and menner as stated.													
S	one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated.													
	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (MC													
BE	Stever	Fegs.	zon!	MD	- Toping	5885	72 1997							
ဥ	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEVEN LIPSON 6121 MONTROSE RD, ROCKVILLE													
		IPSON	6121	MON	TROSE	F RD,	ROCK	«VILLE						
	MAR 0 3 1	997 Julia	GNATURE Davidson-A	indelle										





State of Maryland / Department of Health and Mental Hygiene 97 08377

_							C	ertificat	e of	Death			Reg. No	o.		000		
Physician /Medical			1. Decedent's Nem				2. Dete of Death Month Day Year				3. Time of Death							
			FRE	Saidres					. ~ ~ ~			Year 397	9.	Ca				
/Medica			4a. Facility Neme (WJ.C	4b. City, To	own, or Lo	ocation of Death 4c. County of E				7.0	spin				
/	LAGIIII	ici								Talea	ma P	a wle						
-			5. Social Security N	lumber 6.5	ntist Hos	pital Age (<i>In yrs. i</i> a	st hirthde	If Under	r 1 Year		24 Hrs.			Montg			Caralan	
	uneral irector		251-03-0		180 M 2□ F		Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, D	ay, Year))	Count	ace (State or ry)	Foreign	
	II EC LOI		Usual Residence of			81			L	1		Oct. 15,1915 South Carolina						
D D	ě 11		10a. Stete	10b. County		10c. City,	Town or	Location							10	d. Inside City	Limits	
eath with the Marylar mast be notified at	5	36 1 1													1 🔯 Yes			
	Director	Maryland 10e. Street and Nu		Ade	delphi													
	ā			10f. Zip Code							10g. Citizen of What Country?							
	a	1801 Met:	zerott Ko			20783							ted S		_			
- 8	lter n	Funeral	11. Marital Status		12. Was Decede Armed Force	s?	r In U,S. 13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto						0-	14. Race - American Indlen, Black, White, etc.				
2 1	δĒ			ied 2 Married	If Yes Give	1 Yes 2 □ No		1 Ves 2 Vo Specify:										
21215-0020 d within 72 hours at piene.	50	d by	3 N Widowed	4 Divorced	Yeer or Date:	eer or Dates: 1942-46			X	opcoy.				Specify:	Bla	ck		
2 4	dista	Completed	(Spec	15. Decedent's E	ducation		(G)	cedent's Usu	rk done	during mos	t of work	ina	16b. K	and of Busi	ness/Ind	ustry		
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	£ 8	00	12					Custodian						Board of Edu			n	
D 21	tto A	Be	17. Father's Name	(First, Middle, Last)					18. Mothe	er's Name	ne (First, Middle, Maiden Sum			umame)			
/and	the of	To	Dosha Sanders							Eve	lina	Mixon	Mixon					
Maryland d 2 should be file th and Mental Hy	1		19e. Informant's Na	ame/Relationship (Type, Print)		19b. Ma	ailing Address	(Street	and Numb	er or Run	Rural Route Number, City or Town, State, Zip Code)						
Z 2 €	27 II		Saundra	Coleman			1502	Wheat	on	Lano	Who	aton, l	Max.	1 1	2000	2		
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3	100		Part1. Enter the	he disease, or com	plications that caus	ed the death.	Do not e	enter the mod	le of dyir	ng, such as	cardiac	or respiratory	arrest,	Lington		Approximate		
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	edical		immediate Cause (Final		501	10	10								01		
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و <u>ب</u> و ت	d by	Ph	Posonal orlens daving									1 Yes 2 No 3 Probably 4 Unknown						
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Vision of Vita Attending Physician: or death.	s certificate ha director, pege	9 Be	examiner?		Hospital:				Oth	or:		(Check only						
Division of Vital or Attending Physician: Taffer death.		5 T	1 ☐ Yes 2 27. Manner of Death		28e. Dete of In		R/Outpat 8b. Time		M	4 🗆 🖂	-	me 5 Res		-				
Emg .	After	Certification:	1 Natural	5 Pending	(Month, E	Day Year)	Injury		8c. injur Wor			zou. Describe	ibe how Injury occurred					
Sic	the the	cat	2 Accident Investigation M 1 Yes 2 No															
Division or Attendate defent	Director:	듣	4 Homicide	determined	286. Piece of I	njury - At hom etc. <i>(Specify)</i>	e, farm,	street, factory	, office			28f. Location (City or To	Street an wn, State	nd Number 9)	or Rurel	Route Numbe	97,	
rs al	- De	Ce																
Di To the Hospital or within 24 hours afte	To the Funeral Director: After thi completely filled in by the funeral	edical	29a. Certifier (Check only	1 Certifying Ph	ysician: To the bes	t of my knowle	edge, de	ath occurred	at the tin	ne, date en	d place, a	and due to the	cause(s)	and mann	er as sta	ted.		
1 5 c	plete		one)	Z Medical Exam	niner: On the basis and manner:	steted.	n and/or	investigation,	in my o	pinion, dea	in occurr	ed at the time,	dete end	place, and	d due to t	ne cause(s)		
with t	Tot	Σ	29b. Signature and	title of certifie		/		290	Licens	e number			29d. Da	te signed (Month, D	ey, Year)		
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		-	30. Name end eddre	ssof person who	completed cause of	deeth (Itam 2	3e) /Tvn	a Print)		0	1		, ,,,,	wor	1	1 1 6 1	/	
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	Sta	e	31. Dete filed (Mont	h, Day, Year)	32. Regis	trar's Signatui	re	,								2	UYN	
F	عاد Registra			0 5 1997	Full De	widson 1	Bindal	32.										



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death GEORGE J. SCHUTTE Month Yaar 0230 FEB 1997 25 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospital Columbia Howard | H Undar 1 Yaar | H Undar 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min. | Sept 10, 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foraign Country) Maryland Year) 1899 1 ☑ M 2 ☐ F Yrs. 216-01-1553 Usual Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. fnsida City Limits 1 ☐ Yas 2 No Maryland Howard Ellicott City 10a. Street and Number 10f. Zip Code 10g. Citizan of What Country? 3338 A North Chatham Road 21042 United States 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas ②☐ No If Yas, Giva Yaar or Datas: Was Dacedant of Hispanic Orlgin? (Spacify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Navar Married 2 Marriad 1 Yas 2 No Specify: Specify: 3 Widowad 4 Divorcad White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collaga (1-4or 5+) Bookkeeper Lumber Company 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nema (First, Middle, Meiden Sumame) Gabriel Schutte Veronica Eichhorn 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straet and Number or Rural Route Number, City or Town, State, Zip Code) Carla S. Dahle/daughter 3021 Greenway Drive Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ØCramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Balt-Washington Crematory 2-25-97 Laurel, Maryland 21. Signetura of Funaral Servica Licensee 22. Name and Addrass of Facility Harry H. Witzke Funeral Home, Inc. 16 Klhis 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onsat and Death fmmediata Causa (Final Week disaasa or condition resulting in daath) Due of (or as a consequence of) Sequantially list conditions, if any, laading to Immadlata ceuse. Enter Undarlying Causa (Disease or Injury that Initieted avants resulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was cesa rafarred to medicel axaminar? 26. Placa of Death (Check only one)

Physician /Medical **Examiner**

Physician

Examiner

Funeral

Director

25a-f show must be notified at

items 23a or

b

'natural',

Hygiene.

and Mental

Health

Department of

Important: If them 27 is marked in any injury or other traumatic av

Director

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Completed

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filed within 72 hours after

Pages 1 and 2 should be

Baltimore, Maryland 21215-0020

/Medical

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The law requires that the death certificate be axecuted

Box 68760,

P.O. I

Records,

of Vital

Division

or Attending Physician:

Examiner Physician/Medical þ Completed Be filled in by the funeral To the Hospital or Attendi within 24 hours after deeth To the Funeral Director: A completely filled in by the f

certificate

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29e. Certifian (Check only one) 29b. Signatura and titla of certifian

1 Yas 2 No

1 Netural

2 Accidant 3 Sulcida

27. Mannar of Death

Medical

State

Registrar

Certification: To

28a. Plece of Injury - At homa, farm, straet, factory, office building, etc. (Specify) 4 Homicide Tecrtifying Physician: To the best of my knowledge, deeth occurred et tha tima, dete end place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and plece, and due to the cause(s) and manner stated.

5 Panding investigation

6 Could not be

28a. Data of Injury . (Month, Day Year)

LIN

1 Inpatlant 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Tima of

29c, License number)26621

28c. Injury at Work?

1 ☐ Yas 2 ☐ No

29d. Data signed (Month, Day, Year)

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

Ellicolt City Mcl.

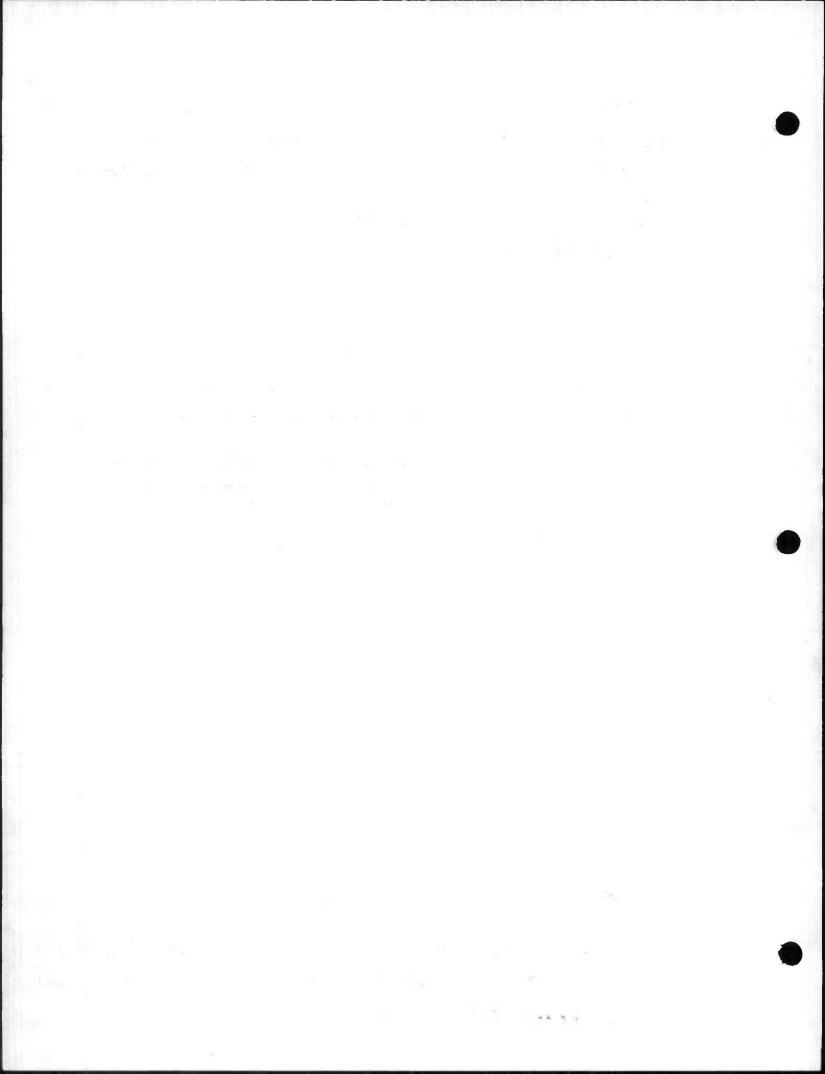
28d. Dascribe how Injury occurred

30. Neme and address of person who complated causa of daath (Itam 23a)-(Type, Print) 3460 Conter Isrive

32. Registrar's Signatura

31. Data filed (Month, Day, Year)

Jalia Studier Ranhell



	partment of Health and	of Health and Mental Hygiene			083	70
Ce	ertificate of Death	Reg	. No.	21	003	1 :
Schaefe	er	2. Data of Death Februar	y ^{Pa} 27,	1 ^{'9} 97	3. Time of 8:15	
give street and number)	4b. City, Town, o	r Location of Death	4c. Coun	ty of Death		

/Medical **Examiner**

Physician

Funeral Director

the Maryland r than 'natural', or items 23s or 28a-f show the Medical Examiner must be notified at death with

filed within 72 hours after Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filled Department of Health and Mental Hygis Important: If New 27 is marked other 8

> **Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the humanimanest. Division of Vital Records, P.O. Box 68760,

10a State Director 10e. Street and Number Funeral 11. Marital Status þ Completed Grade 12 Be Immediata Cause (Final disease or condition resulting in death) Examiner Physician/Medical 2 Completed

1. Decedent's Name (First, Middle Elizabeth 4a. Facility Name (If not institution, 12229 Sleepy Horse Lane Columbia Howard If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Ye Sept 30, 9. Birthpiace (State or Foraign Country) 7. Aga (In yrs. last birthday) 1□ M 21 F Days Yrs. 122-16-3337 70 1926 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 12229 Sleepy Horse Lane 21044 USA 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ∑ No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Nevar Married 2 Married 1 Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middla, Maiden Sumame) John Monsalve Helen Bednarski 19a. Informant'a Name/Reiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Charles J. Schaefer spouse 12229 Sleepy Horse Lane, Columbia, Maryland 21044 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Date 1 ☐ Buriai 2 ☐ Cremation 3 ØRemoval from State 3/3/97 4 ☐ Donation 5 ☐ Other (Specify) Cathedral Cemetery Scranton, Pennsylvania 21. Signature of Funeral Servica License 22. Name and Addrass of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due to (or as a consequance of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of) Due to (or as a consequence of):

Part II. Other significant conditions of	ontributing to death but not re-	sulting In the underlying ca	ause given in Part I.	23b. Did tobacco use co	ontribute to the cause of death
				24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of cause of death?
25. Was casa rafarred to medical				1 ☐ Yes 2 ☑ No	1 Yes 2 No
examiner?	Hospitat: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3☐ DO	Other	eath (Check only ona) Home 5 Aesidenca 6 □Oth	ner (Specify)
27. Manner of Death 1. Natural 5 Pending 2 Accidant investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	Bc. Injury at Work? 1 \(\text{Yes} \) 2 \(\text{No} \)	28d. Describe how injury occur	. 1-1 //
3 Sulcide 6 Could not be determined	28e. Placa of Injury - At h building, etc. (Speci	ome, farm, street, factory,	, office	28f. Location (Street and Numi City or Town, State)	ber or Rural Route Number,
29a. Certifier (Check only one) 1 ☐ Certifying Pr	ysician: To the best of my kno niner: On the basis of examine and manner stated.	owledge, death occurred a ation and/or investigation,	at the time, date and place in my opinion, death occ	ce, and due to the cause(s) and m curred at tha time, date and placa,	anner as stated. and due to the cause(s)
29h Signature and title of certifier	1 -	290	1 Icense number	29d Date signs	d (Month Day Veer)

29b. Signature and title of certifie

29c. Licensa number

29d. Data signed (Month, Day, Year)

1 No 2 No

me

February 27 1947

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)
NICHELAS RUNTRELAKUS 1065 Little Parkixent PKmy Collimbia MO 21044 31. Data filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

and the second of the second o

Funeral Director must be notified at "natural", or items 23s or the Medical Exeminer filed within 72 hours after Baltimore, Maryland 21215-0020 Hygiene. permit. Pagas 1 and 2 should be filled w Department of Health and Mental Hygiens Important: If Nem 27 is marked other tha any Injury or other traumatic

Physician

Physician /Medical Examiner

physicien end s the buriel-transit The law requires that the death certificete be executed ate has been signed by the page 2 should be detached certificate or Attending Physician: this funeral After he Hospital or Attending in 24 hours after death. The Funeral Director: After opletely filled in by the fur

Division of Vital Records, P.O. Box 68760.

To the Within 2 To the State

31. Data filed (Month, Day, Year)

Registrar's Signature

Whit Stwales Radall

pletely

/Medical 4a. Facility Name (If not institution, give streat and number) Examiner Howard County General Hospital Columbia Howard 8. Data of Birth (Month, Day, Year) July 26, 1 5. Social Sacurity Number If Under 1 Year If Under 24 Hrs. 6. Sex Birthplaca (State or Foreign Country) 7. Aga (In yrs. last birthday) 1□M 2/2 F Days Yrs 39 1957 215-15-4083 Bolivia 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director Maryland Howard Clarksville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7337 Pindell School Road 21029 United States 12. Was Decedent Ever In U,S. Armed Forces?

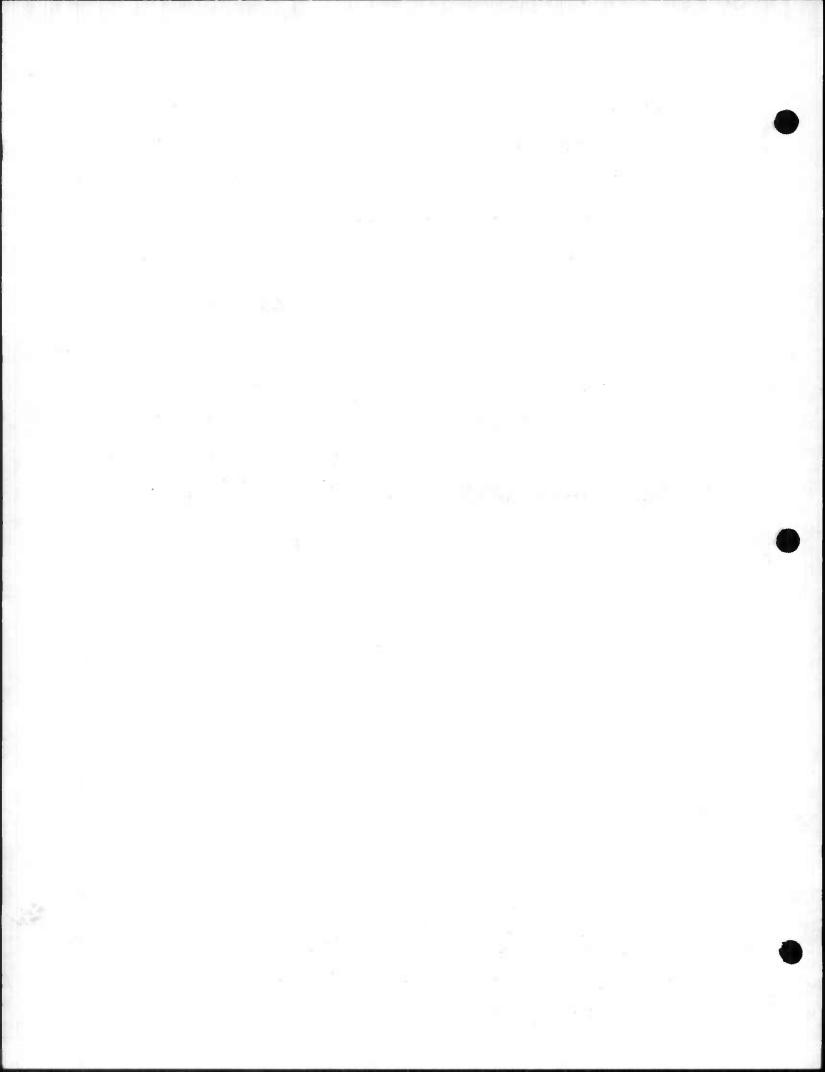
1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Nevar Married 2 🕅 Married Yes 2□ No Specify: þ 3 Widowed 4 Divorced Specify: Boliviana Hispanic Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Pretechnician Medical Laboratory 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Surneme) Be Cecilio Cortez Dioniosia Rojas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) John C. Schmincke III/Husband 7337 Pindell School Road Clarksville, MD 21029 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balt-Washington Crematory 3-3-97 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Nama end Address of Facility Harry H. Witzke Funeral Home, Inc. a Collins 4112 Old Columbia Pike Ellicott City, MD 21043 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heer failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Cause (Final Medusdaylic GASTER diseasa or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, laading to immediata ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24a. Was en autopsy 24b. Were autopsy findings available prior to completion of ceuse of death? 2.2 No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Wes cese referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending 2 Accident Invastigation 1 Yas 2 No 3 Sulcide 6 Could not be determined 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyalcian: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) February 26 1997 10/20/115 30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print)

NICHOLAS KOUTROLAKS 11065 L. 44k Paskern + Pkw, Columbus MD 21044

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black delible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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			O-willians.		(Dankle	

					Cei	rtificate of	Death		Reg. No.	91	1838
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	Physic /Medi		ANNETTE J	UNE	SCHOL	L		februa	my 27 1	1997 3	3:54p.m
)	Examir	ner	4e. Fecility Neme (If not Institution, give	The state of the s			4b. City, Town, or L	ocation of Deet	h 4c. County		
			Stella Maris Hospi				Towsor			imore	
	Funeral Director		5. Social Security Number 6. Sr 162-28-5367	9X 7. Age (In yrs. lest birthday) 67 Yrs.	If Under 1 Yeer Months Deys		8. Dete of Bir (Month, De Jan. 29	by, Year) 9, 1930	Country)	(Stete or Foreign ylvania
	death with the Maryland ms 23a or 28a-f show cmust be notified at		10e. Stete 10b. County	1	Oc. City, Town or Lo	ocation				10d. I	Inside City Limits
	h the Marylari r 28a-f show inotified at	to	Maryland Harfo	rd	Bel Air					1	12 Yes 2 □ No
	or 28	Director	10e. Street end Number			10f. Zip Code			10g. Citizen of	What Country?	
	23a		110 Oak Moore Cou	rt		21014	4		USA	Δ	
020	hours after death with ural', or items 23e or al Examiner must be n	by Funeral	11. Meritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes:		Wes Decedent of if Yes, specify Cul 1 ☐ Yes 2 ☑ No	Hispenic Origin? (Sp ban, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Ble	ce - American Ir ck, White, etc. v: White	
21215-0020	전 불류	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usuel Occu kind of work done	e during most of work	dng	16b. Kind of B	usiness/induatr	ту
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9	-T16		20e. Method of Disposition		20b. Piece of Dispo			Dete		City or Town,	Stete
Ë	Pages nert of nt: If its ry or o		1X Buriei 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify				l Grdns. 3	3-3-97	Fallst	on, Mar	ryland
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	Examiner		resulting in deeth)	e. CLASS	e to (or es e consec	juence of):					<u>_</u>
	D #	ne.	_	ISCHE	MIC C	ARDI	10 MYOF	PATH	4		urs.
	ertificate be executed ing physician and e as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate	Du Du	e to (or es e conseq	juence of):					0
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68760,	physi the	edical	thet initieted events resulting in death) Last	Du	e to (or es e conseq	uence of):					
	ing o	≥		d						i	
Bo	_ 6 3	Physician/						Liver			
Ö	y th	hysi	Pert ii. Other significant conditions co	ntributing to death but r	ot resulting in the u	nderlying cause g	iven in Pert I.				cause of death
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ords	v requires t been signer should be	Completed b							en autopsy omed?	evellab	utopsy findings lie prior to
ec	2 s b	nple				7				of deat	h?
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VIE S	Physician: The tribicate oral director, pag	Be	25. Wes case referred to medical examiner?	Necestal		To	26. Plece of Deet	th (Check only o	one)		
-	Physi this o	2	1 Yea 20 No	Hospitel: 1 Inpatient	2 ER/Outpetien	IL SLI DOA			dence 8 XIOth		OSPICE
0	B 9 6			28a. Dete of Injury (Month, Dey Y	ear) 28b. Time of injury	28c. Inju	ury et ork?	28d. Describe	how injury occur	red	
ouo	F - 5 5	tlon:	1 Neturel 5 Pending		1111						
vision o	Attending I deeth. ctor: After	fication:	2 Accident investigation 3 Suicide 6 Could not be	28e. Pleca of injury		M 1	Yes 2□No	28f. Location /	Street and Numb	per or Rurel Ro	ute Number.
Division	if or Attending after deeth. I Director: After d in by the fune	ertification:	2 Accident investigation	28e. Pleca of injury building, etc. (- At home, ferm, atr	M 1	Yes 2□No	28f. Location (City or To	Street end Numb wn, Stete)	per or Rurel Ro	ute Number,
Division o	spital or Attendin hours after deeth. neral Director: Aft y filled in by the fur	al Certification:	2 Accident 3 Suicide 4 Homicide 29e. Certifier 20 Accident 6 Could not be determined	building, etc. (- At home, ferm, atr Specify)	M 1 C	Yes 2 No	City or To	wn, Stete) cause(s) and mi	anner as stated	1 .
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State Registrar

DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 21204

30. Name and address of person who completed cause of deeth (item 23e) (Type, Print)

Physicia /Medica Examine

Funeral Director

, or items 23s or 25s-f show carsiner must be notified at

Department of Health and Mental Hygiene, institute important: If Item 27 is merked other than "natural", or item any injury or other traumetic event, the Medical Examines, 9008. permit. Pages 1 and 2 should be tiled within 72 hours after Baltimore, Maryland 21215-0020

> **Physician** /Medical **Examiner**

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

					Certific	ate of	Death		Reg	No.	91	083	82
	1. Decedent's Nama (First, Middla, La.	st)							Data of Death	Davi	Yaar	3. Time of E	eath
	GEORGE HENRY	SHI	RINER						ebruary	Day 28,	1997	1:05	PM
	4a. Facility Nama (If not Institution, give	a street and nu	ım <i>ber</i>)				4b. City, Town	n, or Locatio	n of Death	4c. County	y of Daath		
	VA Maryland Healt	h Care	System				Perry	Point	3.7	Ceci	11		
	Social Sacurity Number 6. S	ax XIM 2□ F	7. Aga (In yrs.		Mont	dar 1 Yaar hs Days			ata of Birth Month, Day, Yo	ear)	9. Birthpia Count	ice (Stata or	Foraig
1	217-12-1063	2X IVI 2 I	72	, Y	rs.					1924	Mary		
	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ity, Town	or Location						10	d. Insida City	Limit
	Marriand Harri	ond.		Tral								1 Yas 2	
	MaryLand Harf 10e. Street and Number	ora		Eag	ewood	Zip Coda			100	Citizen of	What Count		
	611 Wingleaf Court				101.	2104	10		109.		What Count	yr	
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	17. Fathar's Nama (First, Middla, Last)						18. Mothar's	Nama (Fin	st, Middla, Mai			011	
	George Andrew Sh	riner					Mary	Regi	na Cas	se			
	19a. Informant's Name/Raiationship (1	Type, Print)		19b.	Mailing Addr	ass (Stree	and Number		uta Number, C	ity or Town	Steta Zin (Code)	
	Dorothy C. Shriner	- Wife	2						ood, Ma			040	
	20a. Mathod of Disposition	713-20	20b. I	Piaca of	Disposition (Nema of		Da			- City or Tow		_
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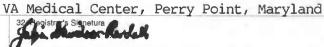
29d. Data signed (Month, Day, Year) February 28, 1997

30. Nama and eddress of person who complated cause of deeth (itam 23a) (Type, Print)

State Registrar

31. Data filad (Month, Day, Year)
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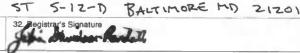
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30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08384 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Deeth ^D26, 1997 Physician February 7:30 p.m. Phyllis Sweatt /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Harford Memorial Hospital Havre de Grace 8. Data of Birth (Month, Day, Year) 6. 1925 Harford if Under 1 Year if Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. lest birthday) Birthplace (Stata or Foreign Country) **Funeral** Months Days 1 ■ M 2 🖫 F 71 Yrs. 228-38-9352 Director Nov. England Usuai Rasidance of Decedant the Manjand 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yas 2 □ No r 28a-f s Maryland Harford Aberdeen 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? mant be n пети 23в 343 S. Deen Street 21001 Funerai England 12. Was Dacedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - Amarican Indian, Black, Whita, atc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yas, Giva Yeer or Detes: 1 □ Nevar Married 2 □ Married altimore, Maryland 21215-0020 5 1 ☐ Yas 2 ☑ No þ Specify: 3 Widowad 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Spacify only highast grade completed) 16b. Kind of Business/Industry Hygiana. Eiamantary/Secondary (0-12) Coliaga (1-4or 5+) 12 House keeping Holiday Inn 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Pages 1 and 2 should be 1 nent of Health and Mental marked Frederick Jones Elizabeth J. Beynon 2 19a. Informant's Name/Raiationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) nt of Health a if them 27 is or other tra Gary S. Sweatt (Son) 407 Ford St., Aberdeen, Maryland 21001 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burlai 2 Cremation 3 Ramovai from Stata 4 Donation 5 Othar (Specify) Harford Memorial Gardens 3/3/97 Aberdeen, Maryland 22. Nema end Addrass of Facility
Tarring-Cargo Funeral Home, P.A. 21 Signature of Funeral Service Licenses Aberdeen, Maryland 21001-3399 23a. Part1. Entar the disaasa, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximata intarvel Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disaase or condition rasulting in daath) Examiner Dua to (or as a consequence of): Examiner The law requires that the death certificate be axecuted burial-transi Sequantially list conditions, if any, laading to immadiata ceusa. Enter Undarlying Cause (Disaasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): attending physician Physician/Medicai the Dua to (or as e consequence of): usa as Part ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by the NoTO 1 Yes 2 No 3 Probably 4 □ Unknown Completed by page 2 should be 24e. Wes an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? peed certificata 1 Yes 1 Yas Attending Physician: 25. Was cesa rafarrad to medical axaminar? director. Be 26. Placa of Daath (Check only ona) axaminar? Hospital: Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Inpatiant Certification: To 2 DER/Outpetient 3 □ DOA this funeral 27. Manner of Daath 28a. Data of injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Dascribe how Injury occurred After Naturai 2 Accidant 5 Pending invastigation death. 1 Tas 2 No 3 Suicida 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Piece of injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida

P.O. Box 68760. Records, Division of Vital after death Director: A d in by the f filled in by To the Hospital within 24 hours a To the Funeral Completaly filled

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

(Check only one) 29d. Data signed (Month, Day, Yaar Lolo 77. 199 29b. Signatura and title of certifian 29c. Licansa number

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29a. Cartifian

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Dete of Deeth Month JebruA By **Physician** ANN JOY SCHEUREN /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Stella Maris Hospice Towson Baltimore 5. Sociei Security Number If Undar 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)

Nov. 28, 1934

8. Birthplace Country)

Kansas 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Hours 1□ M 2♥ F 514-36-6074 Yrs. 62 Director Usuel Residance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. fnside City Limits r 28a-f show s notified at the Marylai 1√ Yas 2 No Director Maryland Harford Aberdeen 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? than "natural", or items 23s or the Medical Examiner must be a 401 Clover Street 21001 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 232 No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - Amarican Indien, Bieck, Whita, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Montal Hygiene. Important if flam 27 is marked other than "natural" or its any injury or other traument. 1 Never Married 2 AMarried Baltimore, Maryland 21215-0020 1 ☐ Yas 2√ No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grada complated) Collega (1-4or 5+) Elemantary/Secondary (0-12) Homemaker In home 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Be Newton Elledge Emma Elliott 19a. Informant's Name/Raletionship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Mr. John F. Scheuren, Jr. 401 Clover Street, Aberdeen, Maryland 21001 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Removal from Stata
4 Donation 5 Othar (Specify) Harford Memorial Gardens 3/4/97 Aberdeen, Maryland 22 Name and Address of Feolity Tarring-Cargo Funeral Home, P.A. 21. Stoneture of Funeral Service Licensee 23a. Part1. Enter the disease, or compile from that caused the deeth. Do not anter the mode of dying, such es cardiac or respiratory arrast, shock, or heer failure. List only one cause on each in a. Aberdeen, Maryland 21001-3399 Approximete Interval Batween Onset end Death **Physician** POLYCYSTIC ASTROCYTOMA /Medical Immediata Cause (Final disaasa or condition rasulting In deeth) Examiner Examiner buriel-transit Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in deeth) Last pue Due to (or es a consequance of) physicien s the buriel Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ate has been signed by page 2 should be detac 1 Yee 20 No HYDROCEPHALUS SIP V/P SHUNT 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? certificate has 2) No 1 Yas 1 ☐ Yas 2 ☐ No offer death.

Director: After this certifica 25. Wes casa raferred to medical Be 26. Placa of Death (Check only ona) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE P 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 27. Mannar of Death 1 Neturel 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury et Work? 28d. Dascribe how injury occurred Certification: 5 Pending 1 ☐ Yas 2 ☐ No Investigation 2 Accidant 6 Could not be datamined 3 ☐ SuicIda Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide

To the Hospital or Atter within 24 hours efter der To the Funeral Directo completely filled in by th

Certifying Physician: To the best of my knowledge, death occurred at the time, deta and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifie 29b. Signeture end titla of certifiar 29c. Licensa number 29d. Dete signed (Month, Day, Year)

30. Nama and addrass of person who complated cause of death (Itam 23e) (Type, Print)

DR. KENDALL FAULKNER 2300 DULANEY VALLEY RD., TOWSON, MD 31. Data filed (Month, Day, Year)

State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08386 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth RALPH **Physician** -E-BUARY 27.1997 .43 P /Medicai 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner MARYLAND THOS PITAL OUTHERN GEORGE 70N If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthdey) If Under 1 Birthplece (State or Foreign Country) . Funeral 1X M 2□ F Months Deys Director 55 216-40-7232 February 3, 1942 Maryland Usuel Residence of Decedent 10e. Stete 10b. County ahow 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1M Yes 2□No Director Maryland Prince George's Brandwine 28a-f 10e. Street end Numbe 10f. Zip Code 10g. Citizen of Whet Country? Items 23a or 12501 Lusby Lane 20613 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2% No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritel Status 1 XNever Married 2 ☐ Married ö 1□ Yes 2 No Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Tricontinental Oil Company 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) Be marked Ralph William Savoy 2 Beatrice M. Savoy 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) .5 Department of Health a Important: If Item 27 is any Injury or other tra once. Beatrice M. Savoy Mother 4695 Homer Avenue Apt. B, Suitland, Maryland 20746 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 1997 Pete 1 D Buriel 2 ☐ Cremetion 3 ☐ Removal from State March 7, Resurrection Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) Clinton, Maryland 21. Signature of Funerel Service Licensee 22. Neme end Address of Fecility Adams Funeral Home, 20605 Aguasco Road, Aguasco, Maryland 23e. Pert1. Enter the disease, or complications that caused the shock, or heart failule. List only one cause on each line. deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner use as the bunal-transit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury thet Initieted events resulting in deeth) Lest Physician/Medical Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 □ Probably 4 □ Hriknown ene by 90 Completed 24b. Were autopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? CQ Q 2000 2 -NO 25. Wes case referred to medical examiner? TO FORENSE TIS THE TOTAL COMPANION TO THE TOTAL Be 26. Place of Deeth (Check only one) OPERATING ROOM Other: 4 Nursing Home 5 Residence 2 2 ER/Outpetlent 3 DOA 6 Other (Specify) Medical Certification: 27. Menner of Death 28b. Time of 28c. fnjury et Work? 28d. Describe how Injury occurred 1 Naturel 5 Pending Investigation ☐ Yes 2 - No 2 Accident

The law requires that the death certificate be executed pue Division of Vital Records, P.O. Box 68760, signed by the attending physician peeu certificata has or Attending Physician: this After death. Director: A aftar within 24 hours aff To the Funeral Di completaly filled in To the Hospital

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Slad within 72 hours after

2 and Mental

Pages 1 and 2 should

Baltimore, Maryland 21215-0020

6 Could not be 3 ☐ Suicide 28e. Pleca of Injury - At he building, etc. (Specification) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e. Certifie 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, and due to the ceuse(s) end menner stated.

29h Signature offines to effic

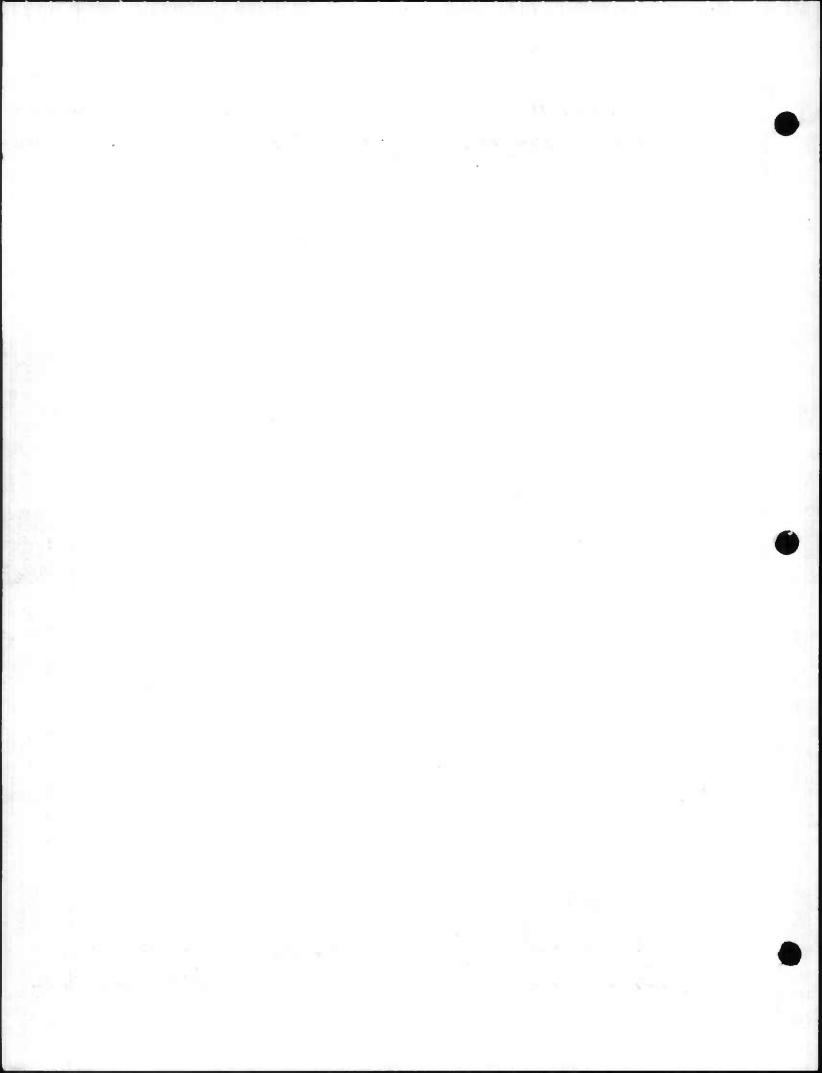
29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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MADEN 32. Begistrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08387 Certificate of Death 1. Decedent's Nama (First, Middia, Last) 2. Data of Death Stiteler ANNA FloreNCE 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Death 4c. County of Death UNION Hospital FIKtON Cecil If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Cauntry) 1□M 280 F 82 211-20-3373 Vre August 16,1914 Usuai Rasidanca of Decedant 10b. County 10c. City, Town or Location 10d, Insida City Limits MD 1 ☐ Yas 2 M No Cec. EIKtON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 126 Castlestone Dr. USA 21921 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, atc. 1 Nevar Married 2 Marriad 1 ☐ Yas 2 🕱 No If Yas, Giva Yaar or Datas: 1 ☐ Yas 2 🖾 No Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedant's Usuai Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Eiamantary/Secondary (0-12) Collaga (1-4or 5+) House Hold Homemaker 18. Mothar's Nama (First, Middla, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Irene Millet William J. Glennan 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) 126 Castlestone Dr. Elkton, m.D. 21921 Lorraine O'Grady 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Buriai 2 □ Cramation 3 □ Ramovai from Stata Glew Mills PA. 3/10/97 Edgewood Mem. Park 4 □ Donation 5 □ Othar (Specify) 21. Signature of simple Service Licensee 22. Nama and Addrass of Facility Gee Funeral Home 259 E. Main St. ElKton, MD. 21921 23a. Pert1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata intarval Between Onset and Deeth Abdomenal Catastrophic Event immediata Causa (Finel disaasa or condition rasulting in death) Dua to (or as e consequence of) Dua to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Alzheimers 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 12 No 1 ☐ Yas 2 ☐ No 26. Piace of Daeth (Check only ona)

Physician /Medical Examiner

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After this cartificate

Hospital or Attendi 24 hours after death. Funeral Director: A

To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the

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Physician/Medical

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Certification: To

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7 is marked other than "natural", or frame 23s or 28s-1 shot fraumstic event, the Modical Examiner must be notified at

bemilt. Pages 1 and 2 should be filed within 72 hours after death value and Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

with the Maryland

Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Causa (Disaase or Injury that initieted events rasulting in death) Lest

Part Ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was casa refarred to medical axaminar? 1 Yas 2 No 27. Manner of Death

1 dinpatiant 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 5 Pending invastigation

28b. Time of

28a. Place of injury - At home, farm, streat, fectory, offica building, etc. (Specify)

28c. Injury at Work? 1 Yas 2 No

Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifian

1 Natural

2 ☐ Accident

3 Sulcide

4 Homicida

1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and piace, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On tha basis of axaminetion end/or invastigation, in my opinion, death occurred at the tima, data and piace, and dua to tha cause(s) and mannar stated.

29b. Signatura and titla of conflier Jacholy-S

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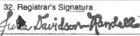
29c. Licensa number D23322 29d. Data signed (Month, Day, Year) 3/6/97

30. Nama and addrass of person who complated causa of daath (itam 23a) (Type, Print)

5. Sachder 118 North St. Elkton, md. 21921 31. Data filad (Month, Day, Year)

State Registrar

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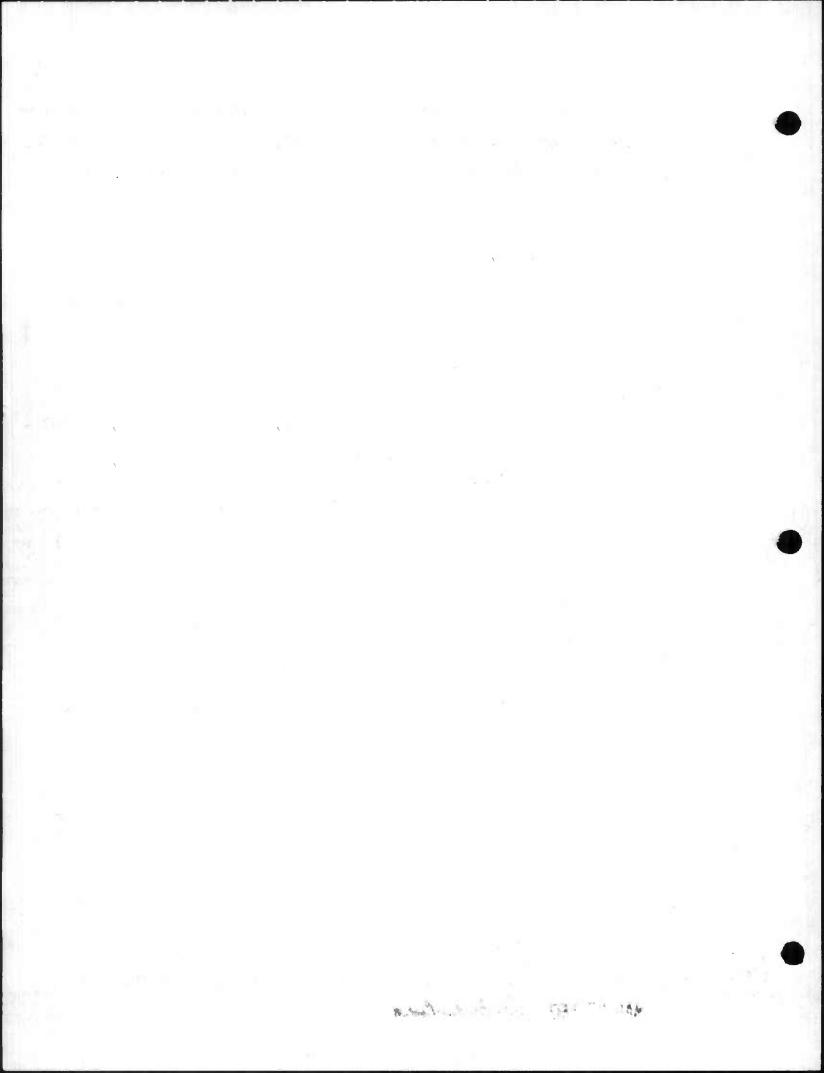
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Maryland 21215-0020	within 72 ha	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		5+)	life. L	kind of w	ork done d ise retired	turina most of wo	rking	16b. Kind of B			
ğ	The Party of	Be C	17. Father's Name (First, Middle, L.	-		пош	emak	=1	18. Mother's Na	me (First, Middle	, Maiden Suman		inc	
/lar	Mental Mental Marked o	To B	Hervey Stanbaug	h					Marce:	lla Gees	sev			
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Baltimore, N	es 1 and of Health (ltam 27 r other tr		Richard B. Shade 20a. Method of Disposition			202 Mo Placa of Dispo- cametery, crem	sition (Na	me of	P. O. 1	Date	Rising 20c. Location			21911
E			1 ☐ Burial 2 ☑ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spe		9	A. Fer				Mar. 6 1997	West Ch	ester	Per	ma
alti	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Li	censee	12.0	22	. Neme e	nd Addres	s of Facility		West off	- occi	9 1 61	111.0 •
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	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	. Cons	estine	H e o	Tro	Fa.	lune				39	35
	P #	ner		D also	Som	- 1	Q A	5 C	VO			1	740	N 6
	ficate be executed physician and as the burial-transit	Examiner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying	b		or as a conseq	uence of)	. ,	* .					11-2
,60,	be ex ician burial		cause. Enter Underlying Cause (Disease or injury that initiated events	c										
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Box	the death certifi y the attending sched for use as	Physician/M		d										
o	9 2 2	ıysk	Part li. Other significant condition	s contributing to death I	but not res	uiting In the ur	nderlying	cause give	en in Part I.		tobacco use co			
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uc	Affect funeral	lon	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury ay Year)	28b. Time of Injury	м	28c. Injury Work	rat k? Yes 2 □ No	28d. Describe	how Injury occur	red		
Division	or Attending after death. Director: After in by the fune	Certification:	2 Accident investiga 3 Sulcide 6 Could no 4 Homicide determin	t be 28e. Place of In	njury - At he				183 2 110	28f. Location (Street and Number or Rural Route Num City or Town, State)		mber,		
۵	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical Ce	(Check only 2 Medicat Ex	Physician: To the best caminer: On the basis of	ot my kno	wledge, death	occurred	at the tim	e, date and place	a, and due to the	cause(s) and m	anner as st	ated.	e(s)
	To the within 2 To the comple	Med	29b. Signature end title of certifier	end manner s	tated.		29	c. License	number	1	29d. Date signe	d (Month)	Day Year	
	F 1 2 5 8) ON 10R 4	· lu \ m	0		(1) -1	1115		Morch			1
	4		30. Name and address of person wi	no completed cause of	death (Iten	n 23a) (Type, I	Print)							
	1		Calandorana	Dentopor	v.	, Risi	ul e	me	, mg.	21911				
	Sta Registr		31. Date tiled (Month, Day, Year) MAR 0.5.1997	in the second	rar'a Signa	Pandelle								

DHMH 16 Rsv 6/95

State of Maryland / Department of Health and Mental Hygiene

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Physic /Medi			ELIZ	2.A	2	mi	THERS		MANO	H 6.		01-24
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unerai irector		5. Sociel Security 225-12 Usuel Residence	2-4839	- W	ge (In yrs. les	st birthday) Yrs.	Months Deys			irth Pey, Year) 28 19	9. Birthplece (Country) Virgi	State or For
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23a or 2	Funeral Director	10e. Street end No	Ishtar	Street,			10f. Zlp Code 207	44		10g. Citizen of U	Whet Country?	
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Funerel Director: After this certificate has been signed by the attendintaly filled in by the funeral director, page 2 should be detached for use	Medical Certification: To Be Completed by Physician/Medical	Sequentially list or if eny, leeding to it cause. Entar Und Cause, Disease or that initiated event resulting in death) Pert II. Other signit SEVERE BRONCE 25. Wes case refe exeminer? 1 Yes SN 27. Menner of Deet 1 Neturel 2 Accident 3 Sulcide 4 Homicide 29a. Certifler (Check only one) 29b. Signeture end 30. Nema and additional signitudes of the cause of t	conditions, mmediate erlying rinjury scheme deserving scheme deserving scheme deserving scheme deserving scheme deserving scheme deserving photosocial scheme des	b. SEVERE c. CHRONI HYPERT d. HYPERT DOINTIBUTE TO GROSIS, R Hospitel: 1 Impatite 28a. Dete of Injut (Month, Denote Duilding, et	Due to (or et a. ATHE Due to (or et a. ATHE Due to (or et a. ATHE Due to (or et a. ATHE Due to (or et a. ATHE Due to (or et a. ATHE Due to (or et a. ATHE Due to (or et a. ATHE Due to (or et a. ATHE Due to (or et a. ATHE Due to (or et a. ATHE Due to (or et a. ATHE Due to (or examination de e	Se consequence of the consequenc	uence of): CLEROTIC uence of): CTIVE PI uence of): ARDIOVAS ARDIOVAS ARDIOVAS LASE ASTHMAS t 3 DOA Ott Wo M 10 aet, fectory, offica coccurred et the tit estigation, in my of 29c. Licens D125	C CORON ULMONAF CULAR van in Part i. FIC 26. Place of D ner: 4 \(\text{Nursing} \) yet k? Yes 2 \(\text{No} \) me, dete end ple pinlon, deeth occ se number 8 8 4	23b. Dic 1 24a. Wa peril 24a. Wa peril 28d. Describe 28f. Location City or Toca, and due to the curred et tha time	ASE. I tobacco use co I toba	YE YE YE YE Ontribute to the c 3 Probably 24b. Were auteveilable complette of daeth? 1 Yes Therefore a complete of daeth? 1 Yes Therefore a complete of daeth? 1 Yes Therefore a complete of daeth? 1 Yes Therefore a complete of daeth? 1 Yes Therefore a complete of daeth? 1 Yes Therefore a complete of daeth? 1 Yes Therefore a complete of daeth? 1 Yes	YEAR ARS ARS. ARS. Opposition of decises and the second of the second

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

7700 Old Branch Avenue, Suite B-102, Clinton, MD

20735

Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** February 28, 1997 Clarence SCOTT 6:00AM /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lanham

f Under 24 Hrs.

Hours Min.

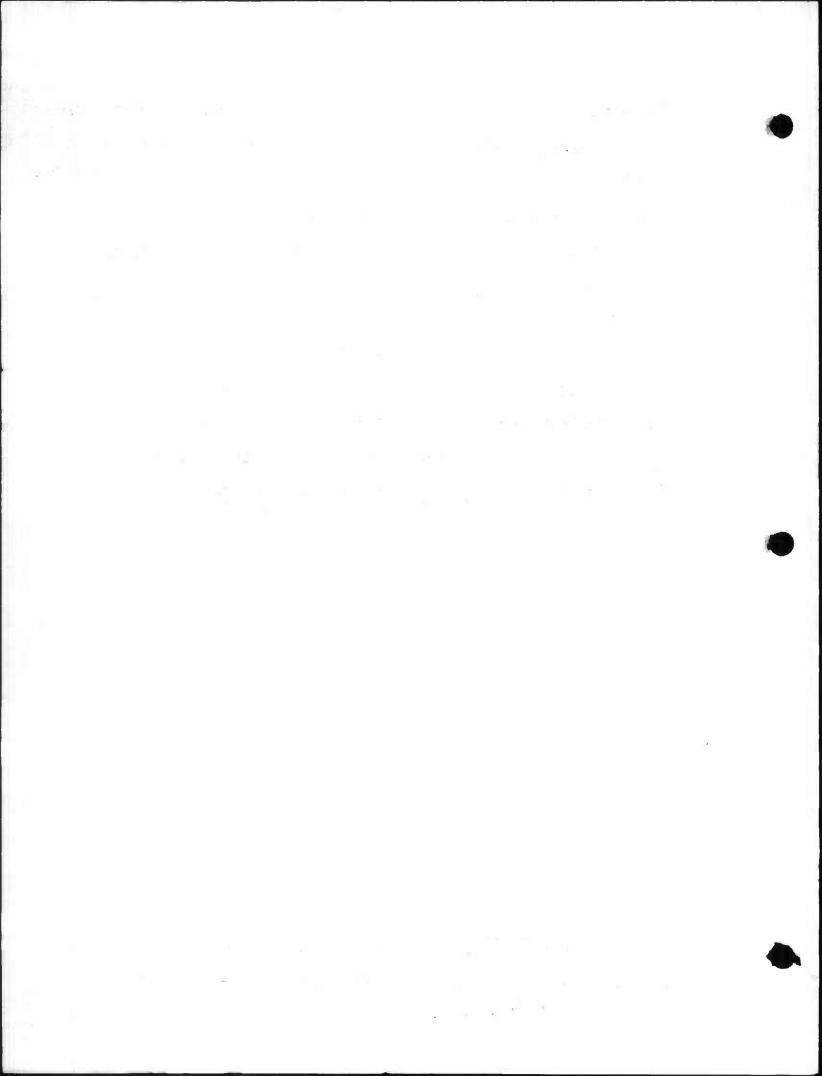
April 5, 1922 Doctors Community Hospital
5. Social Security Number 6. Sax 7. Aga Prince Georges If Undar 1 Yaar 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** 1 □ M 2 □ F Months Days Hours 74 North Carolina Yrs. Director 241-24-2404 the Maryland 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits thems 23s or 25s-f show ther must be notified at Director Prince George's XX Yas 2 No Mary land Spring Dale 10e. Street and Number 10f. Zlp Coda 10g. Citizen of What Country? death with 3508 Tyrol Drive 20774 U.S.A. Funeral 14. Race - American Indian, Black, White, atc. 11. Marital Status 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) "natural", or iten idical Examiner Pages 1 and 2 should be filed within 72 hours after insured of Health and Mental Hygiene.
ant if Item 27 is marked other than "natural", or the way or other transmalls event, the Medical Examinating usy or other transmalls event, the Medical Examination 1 Nevar Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Be Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) Elemantary/Secondary (0-12) Collega (1-4or 5+) Truck Driver Self-Employed 9th grade 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Ira D. Scott Madgie Hawkins 19a. Intormant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Department of Health as Important: If Item 27 is any injury or other trau Mrs. Catherine Proctor (Sister) 3508 Tyrol Drive Spring Dale, Maryland 20774 20b. Place of Disposition (Nama of cematary, cramatory or other place)
Oakwood Cemetery 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1XXBurlal 2 ☐ Cramation 3 ☐ Ramoval from State 3/5/97 Weldon, North Carolina 4 ☐ Donation 5 ☐ Other (Spacify) 21 86 22. Nama and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 ther thy disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, human failure. List only one cause on each line. Approximata Interval Betwe Onsat and Death **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical neumonia **Examiner** Due to (or as a consequence ot) Examiner ician and buriei-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Lest Dua to (or as a consequence of): Box 68760. physician Physician/Medical the Dua to (or as a consequence of) Se USB Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown þ Division of Vital Records, 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 2 2 No 1 ☐ Yas 2 X No 1 Yas or Attending Physician: 25. Was cesa raterred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yas 2 No 70 this 28a. Data of Injury (Month, Day Year) funeral 28b. Time of 27. Mannar of Death 28c. tnjury at Work? 28d. Dascribe how injury occurred Certification: After 1 Natural 5 Panding after death. Director: Aft Invastigation 1 Yas 2 No 2 ☐ Accident n 24 hours after des ne Funeral Director nateiv filled in by the 6 Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, tarm, streat, tactory, office building, atc. (Specify) 28t. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 - Homlcida Hospital edical 29a. Cartifiar 1 Certifying Physician: To tha bast ot my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. To the To the 29b. Signatura and titia of certifiar 29d. Data signed (Month, Day, Year)

State Registrar

July d'Aussian Parlell MAR 03 1997

30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

Essam Y. Tellawi, MD



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	The second secon
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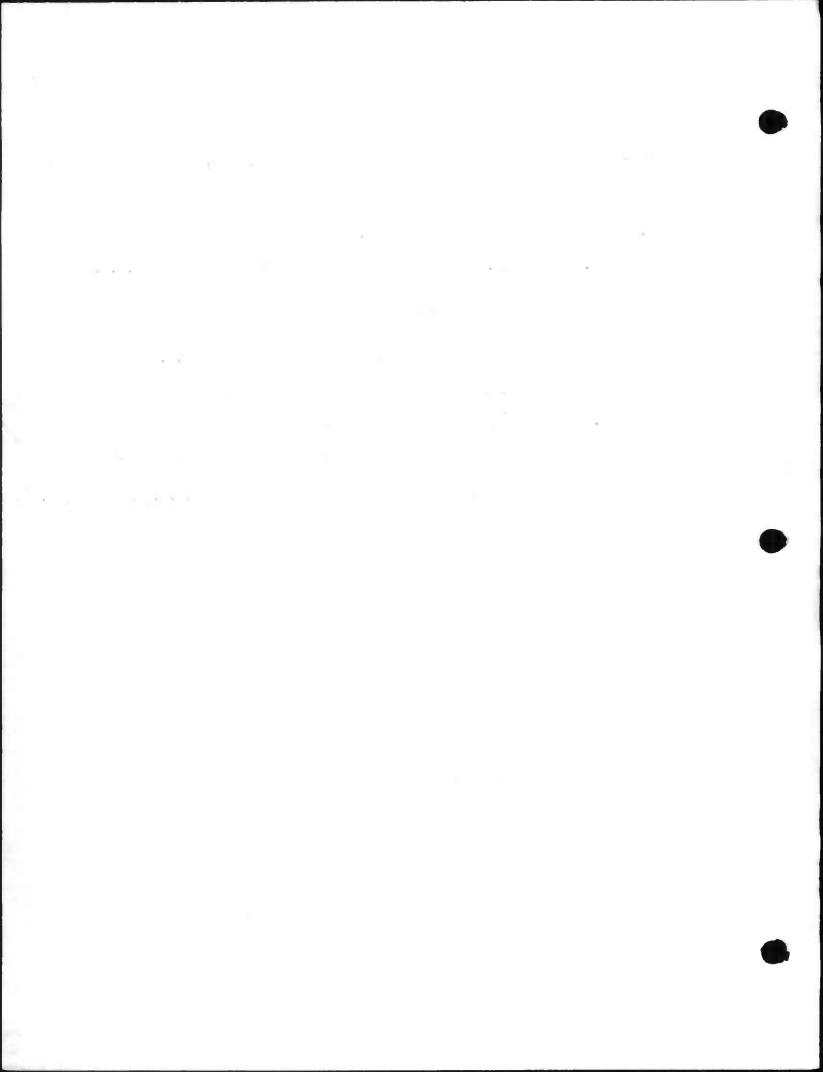
use as the burial-transit permit, Pages 1, 2, 3 should hours after death. Page 6 may be retained by the hospital or attending physician. be detached for notified at completely filled in by the funeral director, page 5 should rial, cremation, or removal. e must examiner medical the event, executed Hygiene prior to burial, traumatic attending physician and other t 6 the atten Mental 1 Injury, signed by the shows any has been signed to Dept. of Health ar 23 Item DIRECTOR; After this certificate hours after death with the State 5 marked, 69 28 Item TO THE HOSPITAL OF TO THE FUNERAL D be filed within 72 hr

t. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH DAY 3. TIME OF DEATH MICHAEL ANTON THOMPSON February 997 est 8:00 рм 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH BIRTHPLACE (State or Foreign Country) MAY 9, 1965 DAY8 HOURS 532-82-0989 1 X M 2 - F YRS. WASHINGTON 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR GREENBRIER STATE PARK **BOONSBORO** WASHINGTON RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? FREDERICK DETRICK t X YES 2 NO 10s. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 1766 B. SHEETS PL. 21701 U.S.A. 11. MARITAL STATUS WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—II yes, specify Cuban, Maxican, Puarto Rican, atc.)
 The Yes of the Specify: 12, WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, atc. FORCES? 1 TY YES 2 IF YES, GIVE WAR OR DATES 2 NO 1 Never Married 2 X Married BY 3 Widowed 4 Divorced Specify: WHITE ACTIVE DUTY COMPLETED 16a. DECEDENT'S USUAL OCCUPATION

(Chan kind of work done during most of working 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) SOLDIER U.S. ARMY 17. FATHER'S NAME (First, Middle, Last) ta. MOTHER'S NAME (First, Middle, Malden Surnam BE (ARMOND THOMPSON ANITA THOMPSON 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 KAREN L. THOMPSON /WIFE SAME AS TTEM 20s. METHOD OF DISPOSITION
1 Surial 2 Cremation 3 Removal from State
4 Donalion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State FIR LANE MEMORIAL PARK SPANAWAY, WASHINGTON 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. M00091 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heert failure. List only one cause on each lina. intervei Betwe IMMEDIATE CAUSE (Final **Onset and Death** disease or condition Self-Inflicted Gunshot Wound to Head resulting in death) moments DUE TO (OR AS A CONSEQUENCE OF) PHYSJCIAN: MEDICAL CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other aignificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 TES 2 XXNO OF DEATH? 1 ☐ YES 2 ☐ NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO INCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL OTHER: t - Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Residence & X Other (Specify) Greenbrier State Park 28a. DATE OF INJURY
(Month, Day, Year)

February 23, 1997est 8M

28a. PLACE OF WALLSTON 27. MANNER OF DEATH 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural BY Self Inflicted Gunshot Wound Investigation 2 Accident
3 Suicide 28e. PLACE OF INJURY — At home, farm, street, lactory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide Greenbrier State Park National Pike, Boonsboro MD 1 _ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, data and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER H 29d. DATE SIGNED (Month, Day, Year) February 25, 1997 DO1062 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Edward W. Ditto, III M.D. 217 W. Washington St. Hagerstown, Md 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE MAR 0 6 1997

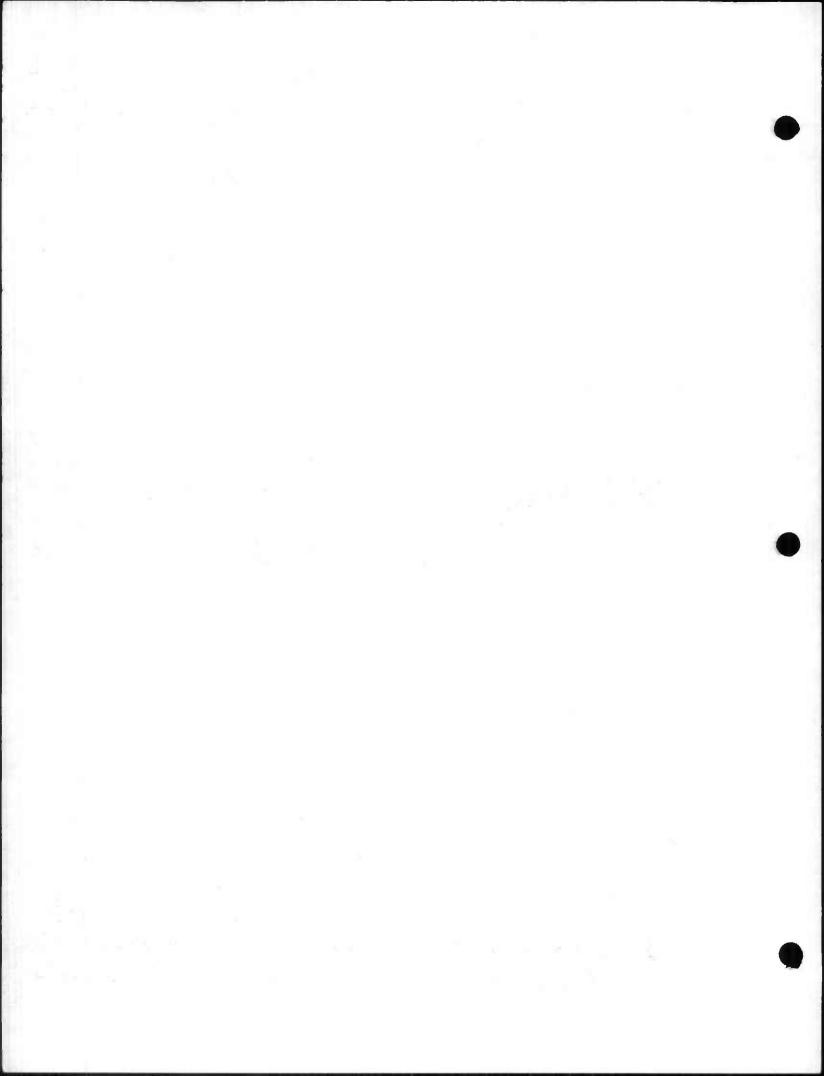


State of Maryland / Department of Health and Mental Hygiene

08392 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Date of Death Month **Physician** 20 P.M MARCH /Medical 4e. Facility Neme (If not institution, give street end number) 4b City Town or Location of Deeth 4c. County of Deeth **Examiner** Mariner Health of Bethesda Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Deys Hours 1 ☐ M 2 🛛 F Yrs. 72 Director 578-90-7426 November 28, 1924 Burma Usue! Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. fnside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f ahow or other treumstic event, it a Medical Examiner must be notified at 1 Yes 2 No Director Maryland Montgomery Bethesda 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6520 Wilmett Road Burma 20817 death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgln? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Marital Stetus permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "natural", or Item any Injury or other treumatic avant 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Dates: Tuber Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specity: Asian Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decadent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 Housekeeper Private Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) U Shwe Hla Daw Ohn Bwint 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kyaw Myint/Guardian 6520 Wilmett Road, Bethesda, Maryland 20b. Pleca of Disposition (Name of cemetery, cremetory or other piece March 4, 1997 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part. Enter the disease, or complication; this chused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cellular to the control of the contr Intervel Between Onset end Deeth **Physician** /Medicai Immediate Cause (Final mediato disease or condition resulting in deeth) Examiner Due to (or es a consequence of) and Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): Box 68760. attending physician thet the death certificate be Physician/Medical the Due to (or es e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Records, P.O. 23b. Dfd tobacco use contributa to the causa of death? signed by t 1 Yes 2 No 3 Probably Unknown p The law requires 24a. Wes en eutopsy performed? 24b. Were autopsy findings avellable prior to Completed completion of cause of death? page 2 this certificate 1 ☐ Yas 2 ☐ No Division of Vital To the Hospital or Attanding Physician: within 24 hours effer death.

To the Funeral Director: After this cartification of the funeral director, it is the funeral director, it is the funeral director, it is the funeral director, it is the funeral director. Be 25. Wes case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To 28e. Dete of Injury (Month, Dey Yeer) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Naturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 ☐ Homicide Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

| Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated. Medical 29e. Certifier (Check only one) 29c. License number 29d. Dete, signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Ceorgetown Rd Botherf mo- 20854 9 Jehalman 9410 010 Je/ 32. Registry's Signature 31. Dete filed (Month, Day, Year) State MAR 0 6 1997 Registrar



State of Maryland / Department of Health and Mental Hygiene

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08393

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death ^{Day} 22, 1997 **Physician** February Joseph R. Toth 12:36pm /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral 1**/□ M 2□ F Days Hours Months Country) Minnesota 476-07-5207 Yrs. 85 Director July 19, 1911 Usual Residence of Dacedent the Maryland 10a. State r 28a-f show Lnotlified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Montgomery Silver Spring 10e. Straet and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be a 618 Gist Avenue 20910 USA Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11 Marital Status 14. Raca - Amarican Indian, Black. White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygene Important: if Nem 27 is marked other than "n any liftury or other traumatic event the Manner Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer Navy 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Andrew Toth Elizabeth Fulytar 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Rosanna Toth / Wife 618 Gist Avenue, Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 → Burial 2 Cramation 3 Removal from Stata 2-27-97 Crownsville, Maryland Maryland Veteran's Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines Rinaldi Funeral Home 21. Signature of Funeral Service Licanse 11800 New Hampshire Avenue Silver Spring, MD20904 23a. Part1. Enter the disaasa, or complications that causad tha death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only ona cause on each line. Approximate Interval Batween Onsat and Death Physician /Medical Immediate Cause (Final disease or condition resulting In death) Congestive Heart Failure 5 Years **Examiner** Due to (or as a consequence of): Examiner 5 Years Arteriosclerotic Heart Disease The lew requires that the death certificate be executed physician end the buriel-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting In death) Last Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or as a consequenca of): attending use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. the 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of causa of deeth? 24a. Was an autopsy Completed peeu has page 2 2 No certificate 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physiolan: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Avaturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 - Homicide 29a. Certifier Two critifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, and due to the ceuse(s) and menner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or Invastigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 1212 10 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

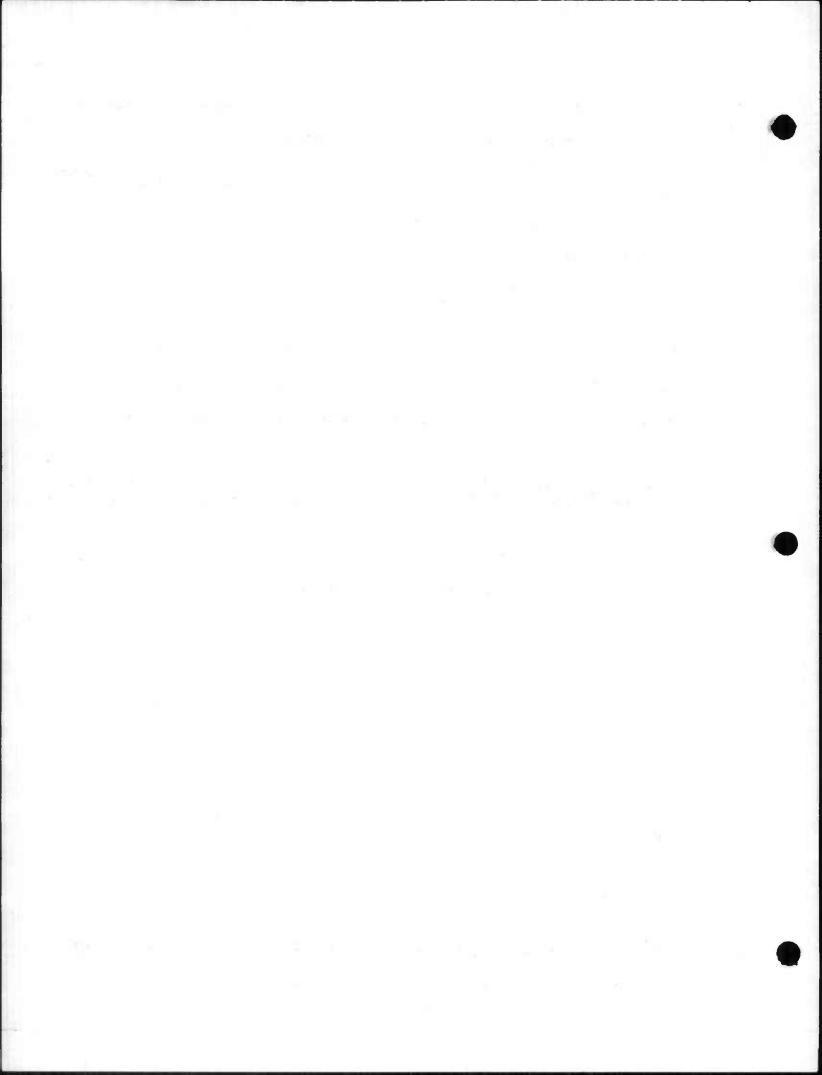
Registrar

State

31. Data filed (Month, Day, Year)
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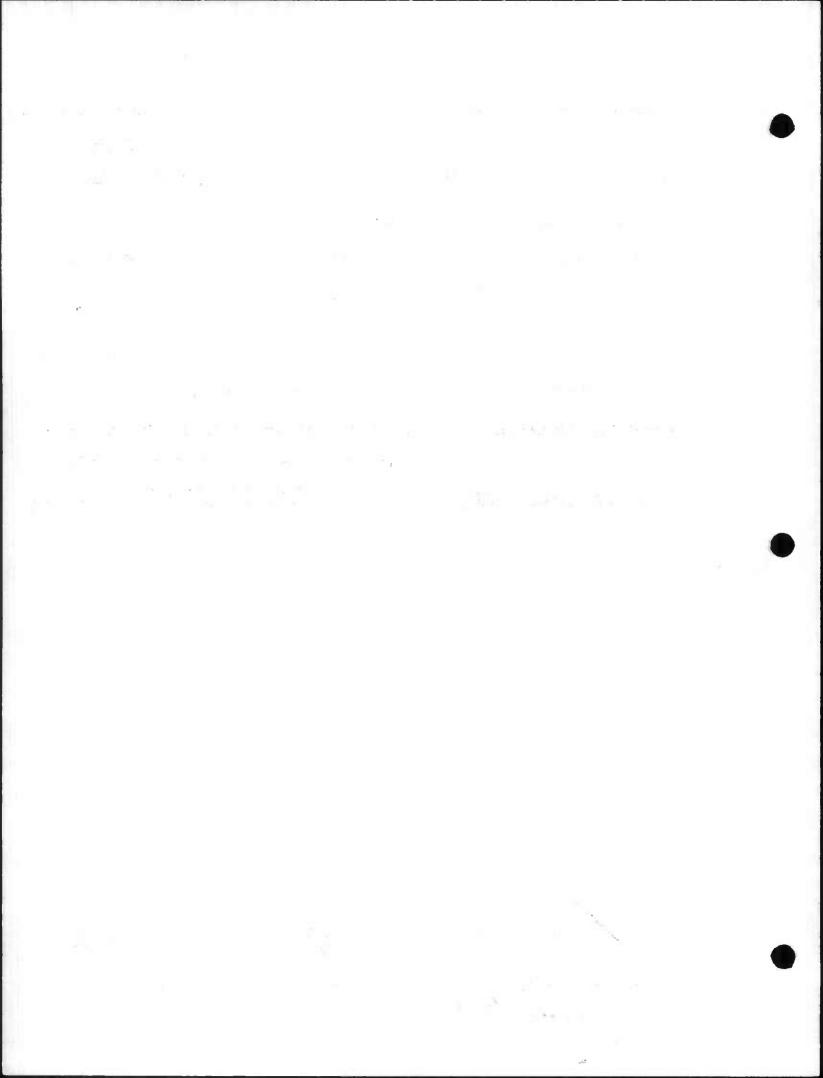
Skie Suidson Rend

George Sengstack, M.D. 3929 Ferrara Drive, Silver Spring, Maryland 20906



State of Maryland / Department of Health and Mental Hygiene

		. Decedant's Name (First, Middl	a, Last)					2. Data of De		Varr	3. Tima of Death
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E 22	1	9a. Informant's Name/Ralations	hlp (Type, Pnint)		19b. Mailin	ng Address (Stre	et and Number or Ri	ural Route Numb	er, City or Town,	Stata, Zip C	Code)
n 27		Jean G. Turner	daughter/	<u> </u>	5535	Phelps	Luck Driv	e Columb	oia, Mar	yland	21045
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State of Maryland / Department of Health and Mental Hygiene 08395 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Voor **Physician** Star Christian Tannehill March 6,1997 11:26pm. /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6570 Glendale Place LaPlata Charles If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth Hours Min. Oct. 4 1982 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) MD Funera¹ Months Days 1□M 2∏F 220-13-9027 14 Yrs Director Usual Rasidence of Dacedant the Maryland 10a. Stata 10c. City, Town or Location r 28a-f show i notified at 10d. Insida City Limits LaPlata MD Charles Tas 2 No Director 10e. Street and Number 10f. Zip Coda 10a. Citizan of What Country? r than "natural", or items 23s or ; the Medical Examiner must be n U.S.A. 6570 Glendale Place 20646 Funeral permit: Pages 1 and 2 should be filed within 72 hours after death Department of the faith and Mental Hygiene. Important if flem 27 is merical other teams any Injury or other trausment of the fact. 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Orlgln? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) Nevar Married 2 Married 1 Yas 2 No If Yas, Giva Yaar or Datas: Specify: White 1 ☐ Yas 2 Ho Specify: þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Minor Minor 17. Fathar's Nama (First, Middia, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Apryl Murray - Gunther George Bruce Tannehill 10 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 6570 Glendale Place LaPlata, MD 20646 Apryl Murray - Gunther 20b. Place of Disposition (Nama of cematary, crematory or other piace) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 3/10/97 Alexandria, VA Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of ffunaral Sarvica Licensas 22. AREHART ECHOLS FUNERAL HOME. MO0945 P.O. box 567 LaPlata, MD 20646 avie 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or haert failure. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physician** AUTODISMOMÍA /Medical Immediate Causa (Final diseasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): Examiner CEREBRAL PALAS The law requires that the death certificate be executed physician and the burial-transit Sequantially list conditions, it eny, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequence of) 82 USB jo signed by the a Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 ☐ Probably 4 ☐ Unknown þ 24e. Was an autopsy performed? 24b. Ware autopsy findings available prior to completion of causa of death? Completed page 2 s 2 No 1 □ Yae 2 □ No certificate Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica 25. Was casa rafarred to medical examinar? Be 26. Placa of Daath (Check only ona) Other: 4 Nursing Homa Standance 6 Other (Specify) 10 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA funeral 28a. Data of Injury (Month, Day Year) Certification: 27. Magnar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred 1-1 Natural 5 Panding 1 ☐ Yas 2 ☐ No 2 -Accident invastigation 6 ☐ Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homleida 1 Certifying Physician: To tha best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medicai (Check only one) To the To the To the 29b. Signatura and titla of certifier 29c. Licanse number 29d. Data signed (Month, Day, Year) 30. Nama and addrass of parson who complated causa of death (Itam 23a) (Type, Print) Krishan m.D 2729, LaPlata, BOX

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

MAR 1 1

32. Registrar's Signatura

Julia Davidson Rardall

State of Maryland / Department of Health and Mental Hygiene

08396 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** James Lancaster Thomas 1997 March 10, 2:16 PM /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 10308 Thrift Road Clinton Prince George's 5. Sociei Security Number If Under 1 Year If Under 24 Hrs.

Months Devs Hours Min. 7. Age (In yrs. last birthday) 8. Dete of Birth Month, Day, Year NOV. 16, 1913 9. Birthplece (State or Foreign **Funeral** Deys Hours 1√2 M 2□ F 578-03-2191 83 Maryland Yrs Director Usuel Residence of Decedent the Maryland 10e. Stete 10b. Count 10c. City, Town or Location 28a-f show 10d. Inside City Limits Director Maryland Prince George's 1 ☐ Yes 2 No Clinton 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 8 10308 Thrift Road 20735 U.S.A. Nerms 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 2 3 4 o If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stafus 14. Rece - American Indien, Bieck, White, etc. 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 'natural', or White 1 ☐ Yes 2 No Specify. þ Specify 3. Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiens. Government Elementery/Secondary (0-12) College (1-4or 5+) PRO-Commissioner Maryland State 12th 17. Fether's Neme (First, Middle, Last) N/A marked other 18. Mother's Neme (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental James Llewlyn Thomas Effie Hancock 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) ā James D. Thomas (Son) 7043 South Owens Way Littleton Colorado 80127 mportant: If Item 27 iny Injury or other tr 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, Sfete Marchat 4, Buriel 2 Cremetion 3 Removel from State Christ Episcopal Ch. Cem. 1997 Clinton, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Lee Funeral Home, Inc. 21. Signeture of Funerei Service Licensee 6633 Old Alexandria Ferry Rd Clinton, Maryland 20735 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) 440025 Examiner Due to (or es e consequence of) Examiner The law requires that the death certificate be axecuted burial-transit and Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in death) Last Due to (or es e consequence of) Records, P.O. Box 68760. Physician/Medical the Due to (or es e consequence of) USB as been signed by the a should be detached f Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? þ Completed 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en autopsy performed? page 2 1□Yes 20 No certificate 1 🗆 Yes 20 No Division of Vital tal or Attending Physician: The star death. director. 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by tha luneral 28a. Dete of Injury (Month, Day Year) Certification: 27. Menner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending Investigation 1 Neturel 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours at To the Funeral Di JE Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner as steted.

2 Medical Examinar: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end piece, and due to the cause(s) and menner stated. Medicai 29a. Certifier 29b. Signature and little of certifier 29c. License number 29d. Dete signed (Month, Dey. Year) 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Harvey Katzen, MD 8926 Woodyard Road #201, Clinton, Md 20735-4218 31. Dete filed (Month, Dey, Yeer) 32. Registrer's Signeture State Habi Studeor Rawfall MAR 1 Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

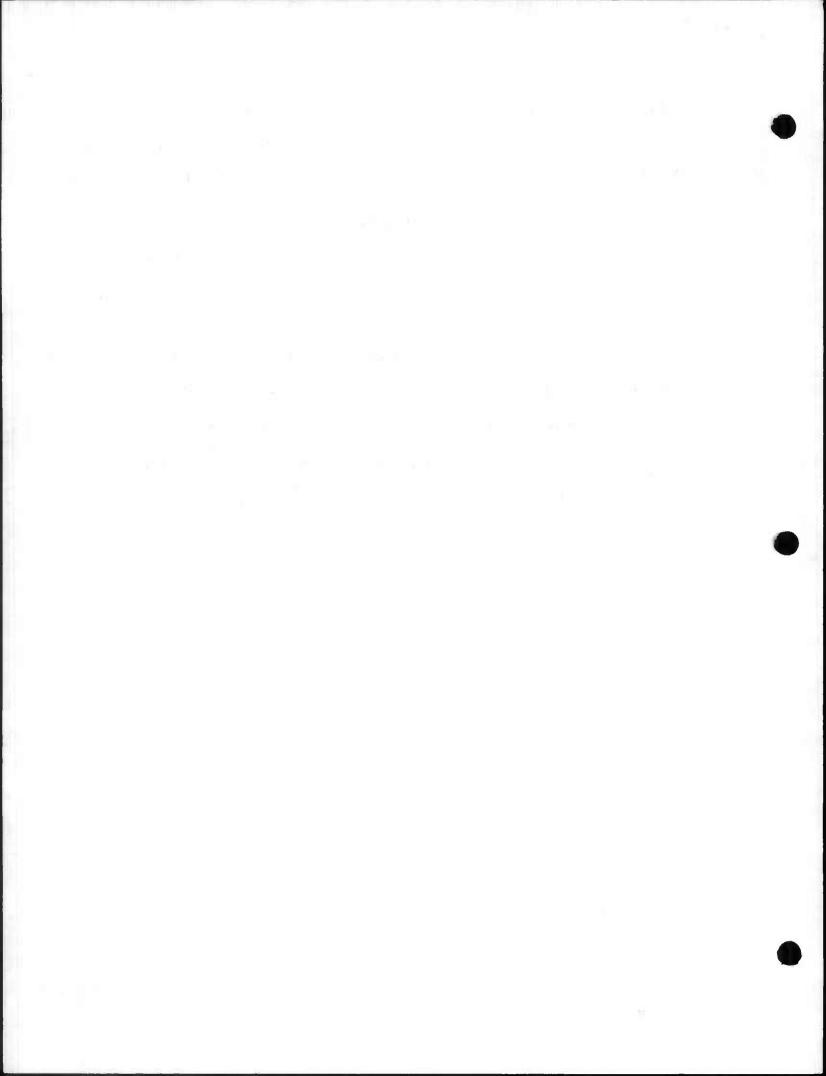
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Physician /Medical Examiner		23a. Part1. Entar the disaasa, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	plications that caused on a causa on each life a.	ne.	c not enter the	mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
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DHMH 16 Rav 6/95

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12	te	30. Neme and address of person who con the filed (Month, Dey, Year) MAR 0 5 1997	ompleted cause of der FUN UT 32. Registrer Fulli Dav	111	e, Print) Penn S	treet, B				



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

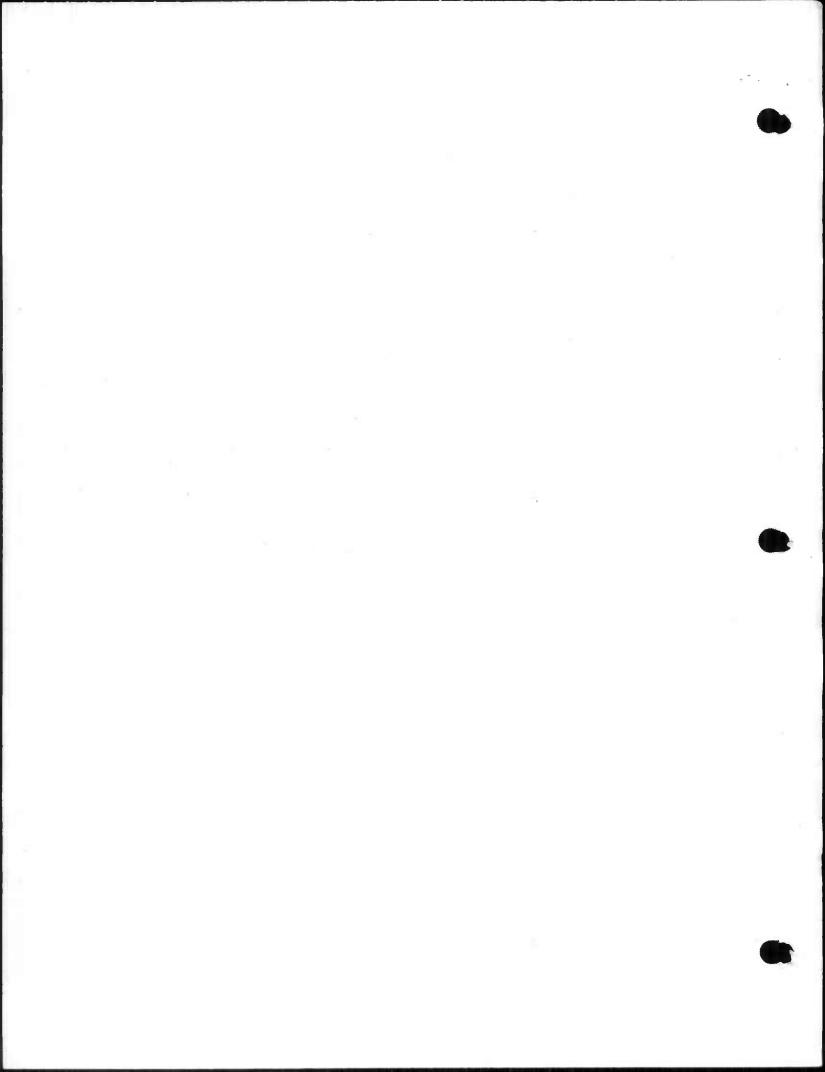
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be netified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs.		IF UNDE	R 1 YEAR	IF UNDER	24 HRS.	_	E OF BIRTH	- (PLACE (State or Foreign
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	20a, METHOD OF DISPOSITION 1 1 Buriel 2 Cremetion 3 Remo	oval from State		EANDDATE					D/	TE 20c, LO	CATION -	City or To	wn, Stata
	4 Donation 5 Other (Specify)		BETH	DAVII	CEN	IETEI	RY		3/5	1/97 L	ONG	ISLAN	D, NEW YORK
- 1	21. SIGNATURE OF FUNERAL SERVICE LE	ENSEE / /	1100	-	22.	NAME AN	D ADDRES	S OF FA	CILITY				
	1/////////	11.00	261										ELS, INC.
_	Total -	Jule)	11	170 I	ROCKV	ILL	E P]	KE ROC	KVIL	LE, M	D 20852
	23. PART I. Enter the diseases, or cahock, or heart feliure.	complications that	ceused the	death. Do r	ot enter	tha mo	de of dyle	ng, auc	h aa ca	irdiac or reapi	ratory ar	reat,	Approximata
ı	IMMEDIATE CAUSE (Final	List only one cau	Se Dii Macii ii	rre.									Interval Between Onset and Death
		. ATHE	=20 <	VIE	2071	^	HEA	-2-T		DISF-AC	E		4 GARS
	resulting in death)	DUE TO	(OR AS A CONS	SEQUENCE OF	F):	_	1601	1 1		0(-0.1=			(0)1
_				7/2	,								
CERTIFICATION	Sequentially flat conditions,	DUE TO	OR AS A CONS	SEQUENCE OF	F):								-
AT	if any, leading to immediate cause. Enter UNDERLYING				,-								i i
윤	CAUSE (Disease or injury	C. DUE TO	OR AS A CONS	SECULENCE OF	F).								
Ē	that initiated events resulting in deeth) LAST	222 101	me m oung	OULITUE UI	,,								i
H		d											
	PART II. Other aignificant condition	a contributing to	death but no	t resulting	in the ur	nderlylna	Cause a	iven in	Part i	24s. WAS AN	Alfmaev	944	WERE AUTOPSY FINDINGS
3		MENTIA		and a		- arry mg	, g			PERFOR		240.	AWAILABLE PRIOR TO
EDICAL		TE IN CHIT							_	1 TES 2	NO		COMPLETION OF CAUSE OF DEATH?
Σ													1 TYES 2 NO
	DID TOBACCO USE CONTE	RIBUTE TO CA	USE OF DE	ATH YE	S 🔲 I	NO.	UNC	ERTAIN	V				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PL	ACE OF DEAT	TH (Check	only one)							
is l	1 YES 2 NO	HOSPITAL:	ER/Outpatient	3 DOA	OTHE!		4 D	airianna	a 🗆 🗪	her (Specify)			
≟	27. MANNER OF DEATH	28a. DATE OF	INJURY	28b. T/M		28c, INJU		eluence .		ESCRIBE HOW II	ALURY OC	CUBED	
	Natural 5 Pending	(Month, De			URY	WOI	RK?	I NO	200.0	Lyonne non II	JUNT UC	VONED	
À	2 Accident Investigation	28a BI ACE OF	IN HIDY A	home for				, no				-	
	3 Suicide 8 Could not be 4 Homicide determined	building,	F INJURY — At etc. (Specify)	nome, term, s	RIBBE, fact	ory, office				CATION (Street a by or Town, State)	nd Numbe	r or Rumi R	oute Number,
교비	29a. CERTIFIER (Check only CERTIFYING PHYSIC	CIAN: To the best of	my knowledge,	death occurre	d at the f	lme, deta	end place.	end due	to the c	euse(a) and man	ner en ste	ted	
COMPLETED	one) 2 MEDICAL EXAMINE												and manner as stated
	29b. SIGNATURE AND TITLE OF CERTIFIER									, ,	IV II	(4)	
BE	0		104.0				29c. LICE		_				(Month, Day, Year)
2		lurar					カ	36	555	2	M	ARCH	2 1997
-	30. NAME AND ADDRESS OF PERSON WHO		-										
		5121 M	IONTRI	OSE	Ro	AD.	R	00	KV	LLE	M	0.20	852
	31. DATE FILED (Month, Day, 16er) MAR 0 5 1	99 32. REGISTRA	is signature	don to	ndopp								
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State of Maryland / Department of Health and Mental Hygiene

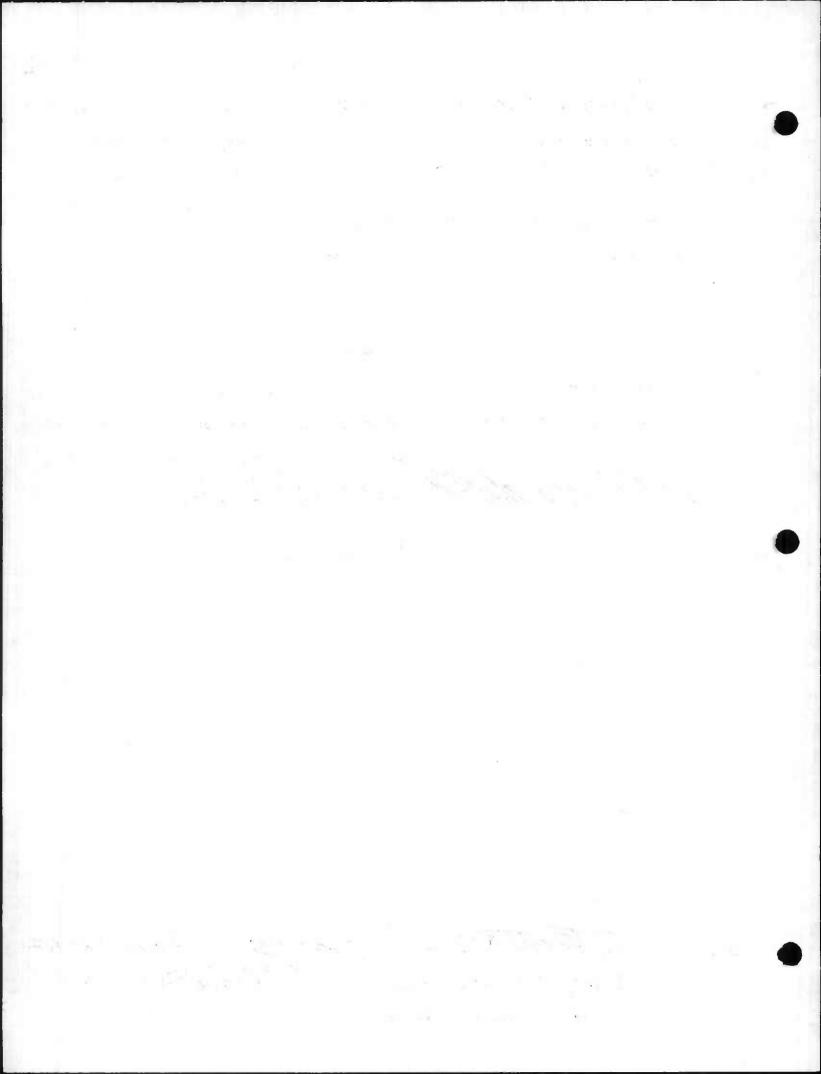
10		1. Decedent's Name (First, Middle,	Last)					2. Dafe of De		3.	Time of Deat
Physici /Medic		ROY	H. WE	LLS				Month Fe	b 27 1	Year 447	859
Examir		4a. Facility Name (If not institution,	give street end number	r)			4b. City, Town, or	Location of Deat	4c. County	of Deeth	
		HOLY CROSS	HOSPITA	L			SILVER	SPRIN	G MON	TGOME	RY
Funeral Director		5. Social Security Number 577-12-3308 Usual Residence of Decedent	6. Sex 7. A 1 M 2 □ F	78		Inder 1 Year oths Days		8. Date of Bir (Month, De	L4, 1918	9. Birthpiace Country) VIR	(State or For
Mow		10a. State 10b. County		10c. Cify,	, Town or Location	1				10d. I	nside City Lir
r 28a-f show notified at	Director	MD. MONTG	OMERY		SILVE	SPR	ING			1	X Yes 2□
or 22 De no	Oire	10e. Street and Number			10	f. Zip Code			10g. Citizen of W	hat Country?	
25 H			h ST. #7	16			910			S.A.	
af, or items Examiner m	by Funeral	11. Marifei Sfetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Deceden Armed Forces d 1 X Yes 2 If Yes, Give Year or Dates:	?] No	1 D V	ecedent of I specify Cub s 2X No	Hispenic Origin? (Span, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Raca Black Specify:	- American II	
# H	ba	15. Decedent's			16a. Decedent's	Usual Occur	pation		16b. Kind of Bus	WHI siness/Industr	
r than 'ne the Medic	Completed	(Specify only highest Elementary/Secondary (0-12)	grede completed) College (1-4or 2	5+)	(Give kind of life. DO NO	of work done OT use retire	during most of wo	orking	UNITE	D ELE	•
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arkad arkad	ToE	ROY	WELLS					ANNE	LAW	S	
Tang Tang		19a. Informant's Name/Relationship			19b. Mailing Add	dress (Stree	t end Number or R	urel Route Numb	er, City or Town, S	Stete, Zip Cod	le)
the 20		RUTH L. WEL 20a. Method of Disposition	LS/WIFE	20h Ple	SAME ace of Disposition		ITEM #	10 Dete	20c. Location - (Dibe on Town	Chaha
10 TO TO TO TO TO TO TO TO TO TO TO TO TO		1 ☐ Burial 2 X Cremation 3		ca	metery, cremetory	or other ple					
ulu .		4 ☐ Donetion 5 ☐ Other (Spe 21. Signature of Funeral Service Lic		CH	AMBERS			3/3	RIVER	DALE,	MD.
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State of Maryland / Department of Health and Mental Hygiene

08402 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** ADRIEN March 1, WESTERBAND M.D. 1997 11:55 am /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 304 Flannery Lane Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, 9. Birthplece (State or Foreign Country) Haiti 7. Age (In yrs. lest birthday) Funerai 1⊠M 2□ F Months Deys N/A 72 Yrs. Director 2, Dec. Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location show 10d. İnside City Limits Director 1 ☐ Yes 2 ☑ No notifie Maryland Montgomery Silver Spring 10e. Street end Number 10f. Zin Code 10a. Citizen of Whet Country? Nume 23s or must be 304 Flannery Lane 20904 Funeral Haiti 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 'natural', or Iter dical Examiner hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2K Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorcad Specify: Black Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 72 Elementery/Secondery (0-12) College (1-4or 5+) 12 5+ Physician Medicine permit. Pages 1 and 2 thoust be file.
Department of Health and Manial Hygingortant if them 27 is marked any Injury or other 17. Fether's Neme (First, Middle, Last) Be 18. Mother's Neme (First, Middle, Meiden Sumeme) 2 Alexis Westerband Unobtainable 19e. Informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Dany Westerband, M.D. / Son 304 Flannery Lane, Silver Spring, Maryland 20904 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete 1 ☐ Burlei 2 ☐ Cremetion 3 ☒ Removel from State 4 Donetion 5 Other (Specify) 3/12/97 Haiti, West Indies 21. Signeture of Funeral Service Licensee 22. Name and Address of FacilityHines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Death Physician /Medical Immediete Cause (Finel diseese or condition resulting in death) **Examiner** Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest for use as the bunal-tran Due to (or es a consequence of) P.O. Box 68760, Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Ď 2 24b. Were autopsy findings evelleble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? certificate has 1 Yes 2 No Physician: Be 25. Wes case referred to medical exeminer? 26. Plece of Death (Check only one) 2 Other: 4 Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 PResidence 6 □Other (Specify) this 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After the Attendance of the funeral filled in by the fur 1 Maturel 5 Pending Investigation Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, dete and piece, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end menner stated. Medicai (Check only one) 29b. Signature and title of one 29c. License number 29d. Date signed (Month, Dey, Year) 0 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) 304 Flannery Lane WESTERBANS M·D Silver Spring, Maryland 20904 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Registrar white Davidson MAR 0 4 1997

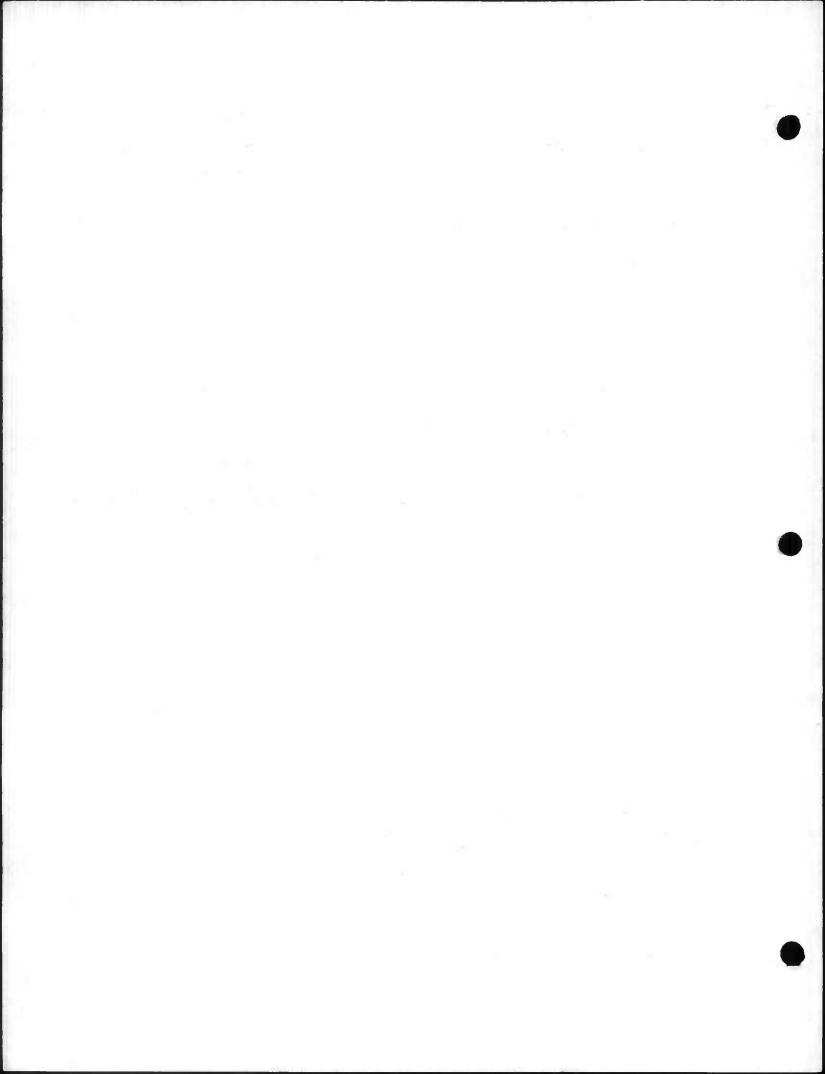


State of Maryland / Department of Health and Mental Hygiene

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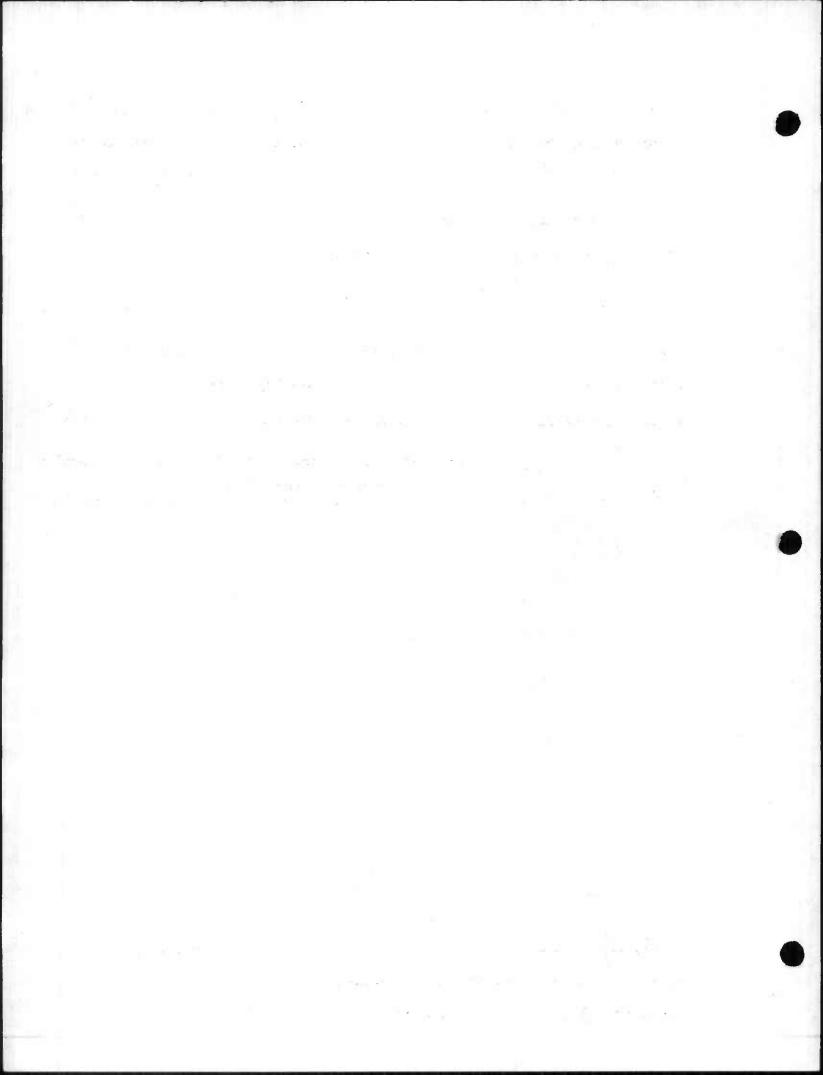
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	. 1	1. Decedent's Name (First, Middle	e, Last)					2. Date of Dea	th	Vans	3. Time of Death
Physic		Michael O	Brien Willi	ams				Februar	Day 22, 1	Year QQ7	4:30_PM
/Medi Exami		4a. Facility Name (If not institution					4b. City, Town, or		4c. County		4:30_PM
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Funeral	г	5. Social Security Number	6. Sex 7. As	ge (In yrs. last bii		r 1 Year	If Under 24 Hrs	pring 8. Date of Birth	Vasal	ntgon 9. Birthp	lace (State or Foreign
Director		N/A	1 ½ M 2□ F		Yrs. Months	Days	Hours Min.	FEB. 22,		Coun Maryl	try)
9	1	Usuai Residenca of Decedent								riary	and
of the last	١.	10a. State 10b. County		10c. City, Tow	n or Location					1	0d. Inside City Limits
the Maryland 28a-f show notified at	io io	Maryland Monte	romerv	Kensir	neton						1 X Yes 2 □ No
2 5 5 E	Director	10e. Street and Number				Code		1	0g. Citizen of 1	What Coun	try?
23s will	al	4211 Colchester	Drive			208	395		U.S	Δ	
E B 8	Funeral	11. Marital Status	12. Was Decedent Armed Forces		13. Was Dece		Hispanic Origin? (S pan, Mexicen, Puer	pecify Yes or No-	14. Rac	e - Americ	
n a di	F	1 Never Married 2 ☐ Marr					Specify:	to ritoan, etc.)		ck, White,	9(G.
Fair.	l by	3 Widowed 4 Divorced	Year or Dates:		1 103	290110	opecny.		Specify	γ.	White
filed within 72 hours after death with the Maryla ther than "natural", or items 23s or 25s-f show wif, the Medical Examinar must be notified at	Completed	15. Deceden	t's Education st grade completed)	16a	Decedent's Usu	rk done	during most of wa	rkina	16b. Kind of B	usiness/Ind	
Man of	npidu	Eiementary/Secondary (0-12)	College (1-4or	5+)	life. DO NOT	se retire	ed)				
	Co	N/A			N/A		Т		N/		
0 = 0 5	Be	17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle, I	Maiden Suman	10)	
should b nd Menta marked umafic a	2	William B. Wi	lliams				Sus	an O'Bri	en		
22 sh and and and and		19a. Informant's Name/Relations	hip (Type, Print)	19b	. Mailing Addres	s (Stree	t and Number or R	ural Route Numbe	, City or Town,	State, Zip	Code)
26 - 100 Dec 1		William B. Wi	lliams	42	211 Colc	hest	er Drive	Kensing	gton, Ma	rylar.	d 20895
ges 1 a f. of Hear if them or othe		20a. Method of Disposition 1 Burial 2 □ Cremetion	2 □Removal from State	com oto	f Disposition (Na ry, crematory or	me of other pla	ace)	Date	20c. Location -	City or To	wn, State
Pages mant of ant: if the ury or o		4 Donation 5 Other (S			f Heaver	Ce	meterv	3/01/97 5	ilver	Sorin	g,Maryland
permit. Pages 1 at Department of Hea Important: If New 3 any Injury or other 9058.		21. Signature of Funeral Seavice	Licenson		22. Name a	nd Addre	ess of Facility				5, mar y ramo
89778		Kobute	Kamsey	1	Franci	s J.	Collins	Funeral	Home,	Inc.	MD 20001
ALC: U		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	d the death. Do	not enter the mo	de of dy	sity Blv	Correspiratory err	tver Sp est,	ring,	Approximate
Physician		shock, or heart failure. List	only one cause on each I	ine.							Interval Between Onset and Death
/Medical	ш	Immediate Cause (Final	Н.	· M	1		1.	21			131
Examiner		disease or condition resulting in death)	a. Ilya	Duo to for as a	JEW PLA.	16	Viseas	6		1	13 4043
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death le atter ed for u	Physician	Part it. Other significant condition	ons contributing to death b	out not resulting l	n the underlying	cause di	iven in Part I.	23b. Did to	bacco use co	ntribute to	the cause of death?
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2 2 2	ру Р	resumed	Seps.s						,.		
e law requires the has been signe		Presumed Perinatal	,					24a. Was a		24b. We	ere autopsy findings ailable prior to
law rec as bee	let	Perinatal	asphyx,	a sec	ondary	to		perfor	med?	CO	mpletion of cause death?
The law ate has page 2	Completed		DI LI	,	ruption			1 🗆 Y	es 2 No		Yes 2 No
		25. Was case referred to medica	Placental	ab	raption	1	00 Place of Do			1	J 195 2ES NO
	o Be	examiner?	Mosnital: >			Ot	hor	ath (Check only or		(02	
Phys ral di	. To	27. Manner of Death	28a. Date of Inju		tpatient 3□ D	JA	4 🗆 Nursing i	tome 5 ☐ Reside			"
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l or Attending after death. Director: After	Certification:	3 ☐ Sulcide 6 ☐ Could	not be	ury - At home is	arm, street, factor			28f. Location (S	treet and Numb	er or Rura	l Route Number
f or Attending Physafter death. Director: After this in by the funeral d	ert	4 ☐ Homlcide determ	building, et	c. (Specify)		,		City or Town			
To the Hospital or Attending I within 24 hours after dealing to the Funeral Director: After completely filled in by the funeral process.		29a. Certifier 1 Certifyin	g Physician: To the best	of my knowledge	death occurred	at the ti	ime date and nien	and due to the o	aueo/s) and m	nner se ei	leted
Hoa 24 h Fun etely	edical		Examiner: On the basis o	f examination an	d/or Investigation	, in my	opinion, death occi	irred at the time, d	ate and place,	and due to	the cause(s)
ithin on the	Me	29b. Signeture end title of certifie	-	4.04.	29	c. Licen	se number	2	9d. Date signe	d (Month.	Day, Year)
F 3 F 8		Buttle !	0 3.	0		0	2000		51	10	
		Mollen	ward Mi				0505	77	2/0	12/4	1
- I		30. Name and address of person	who completed cause of c	death (Item 23a)	(Type, Print)	H	. 1 1	ICORE	4/1	10 6	ilver Spring, M
1		31. Date filed (Month, Day, Year)	ard M. D	70	ly cross	110	spital,	1500 Ton	estuten	Kd, 3	וועריך ושיוו
Sta Registi		MAD	∩ / 1007 ►	ar's Signature	idson-Rand	200					
negisti	ш	MAIN	V 4 135/ F	Jane vill	May - North						

DHMH 16 Rev 6/95



	O.T.	, 2/25/97, M.W.O.,	Howard Co.	Cer	tificate of	Death		Reg. No.	/ 0840
Physicia /Medic		1. Decedent's Name (First, Middle, Las Lawrence	Wilson				2. Dete of De Februa	try 23	Yeer 7:30 F
Examin	er	4e. Fecility Name (If not institution, give Laurel Regional E 5. Social Security Number 6. Se	Mospital	(and hirthday)	If Under 1 Yaar	Laurel	Location of Deat	Princ	e George
Funeral Director			² Age (<i>in</i> 2	yrs. last birthdey) Yrs.	Months Deys	Hours Mir		W Voor	9. Birthpleca (Stata or For Country) Maryland
r 28a-f show	ctor	10e. Stete 10b. County MD Montgome		c. City, Town or Loc Surtonsvil					10d. Insida City Lin 1 X Yas 2 □
or 28	Director	10e. Streat and Number			10f. Zip Code			10g. Citizen of V	Whet Country?
, or items 23s or	by Funeral	4120 Sandy Spring 11. Meritel Status 1 Navar Married 2 Married 3 Widowed 4 X Divorced	12. Was Dacedant Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Give		20866 Ves Decedent of I Yas, specify Cub ☐ Yes 2♥ No		Specify Yas or No rto Rican, etc.)	USA 14. Race Blec Specify	e - American Indien, kk, White, atc.
than "natural". The Medical Exp	Completed b	15. Decedent's Ed (Specify only highest grad	Yeer or Detas: ucation de completed) College (1-4or 5+)	(Give k	ent's Usuel Occu kind of work done OO NOT use retire	during most of w	orking	16b. Kind of Bu	White usinass/Industry
d off	Be	Elamantery/Sacondery (0-12) Grade 12 17. Fether's Neme (First, Middle, Last) Caleb Wilson		Carper	nter		ome (First, Middle,	Carpent	
Trate	2	19a. Informent's Name/Reletionship (7) Evelyn Schetromph				end Number or F	Pural Route Numb		Stete, Zip Code) 2086 , Maryland
nent of Health rut: If Item 27 f iry or other tri		20e. Mathod of Disposition 1 Buriel 2 Cremetion 3 4 Donation 5 Other (Specify	Removel from State	0b. Plece of Dispos	sition (Neme of etory or other ple	ce)	Dete	20c. Location -	City or Town, Stete
Department of freportant: If any injury or once.		21. Signeture of Funeral Septice Licen		22. Do	Neme end Addre	ess of Fecility Funeral	Home, P	.A.	20707–4389
ysician Medical caminer		23e. Pert1. Enter the disease for comp shock, or heert faild. List only complete Ceuse (Finel disease or condition rasulting in deeth)	a. ISCHEMIC	to (or as e consequ	Dony	ng, such es cardio	c or raspiratory a	rrest,	Approximeta Interval Between Onset and Deelh
hysician and the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	b. Due	to (or es e consequ	uence of):				
G 99	8	Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest	d.	to (or es a consequ	ience of):				
e atten	Physician/M	Part II. Other significant conditions co	ntributing to death but no	t resulting in the un	deriving cause giv	ven in Pert I.	23b. Dld	tobacco usa con	ntribute to the cause of de
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5.8								en eutopsy	24b. Were autopsy findin available prior to
as been signed by the a 2 should be deteched	npieted						perfo	imear	of deeth?
ate has page 2	Completed						10.	Yas 28 No	completion of cause of deeth?
ector, page 2	Be	25. Wes case refarred to medical examiner? 1 □ Yes 2 ☑ No	Hospitel: 1 Minnatient	2 ☐ FR/Outpatient	3□ DOA Ott	205	1 🗆 '	Yas 2 TNo	of deeth?
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DHMH 16 Rav 6/95





Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	1. Decedent's Name (First, Middl	lo Loct)		Certificate of	Doutin	2. Date of D	Reg. No.	21	08405
ian	Torre	L. WHITE	TD			Month	Day	Yeer	3. Time of Death
ical ner	4- 2-16-16-16-16-16-16-16-16-16-16-16-16-16-		014.		4b. City, Town, or	Februa		997 ty of Deeth	10:00 P, 1
161	HOSPICE of P				Mount R	anier		ce Geo	rges
П	5. Social Securify Number	6. Sex 7. Age	e (In yrs. lest birtho			8. Date of B	rth	9. Birthple	ace (Stete or Foreign
	578-05-5300	XIXM 2□ F 86	years y	s. Moritis Deys	nours Min.	Oct 24			ssippi
	Usual Residence of Decedent 10e. State 10b. County		10c. City, Town of	or Location				10	d facido City I Imite
5		ce Georges	Mount Ra					10	od. fnside City Limits
Director	10e. Street end Number			10f, Zip Code			10g. Citizen of	What Count	
		a.t		20712					of Americ
Funeral	11. Maritei Status	12. Wes Decedent E	Ever in U,S.	13. Was Decedent of	Hispenic Orlgin? (S	pecify Yes or N	o- 14. Re	ca - America	n Indien,
		Armed Forces? ried 1 □ Y Yes 2 □ N If Yes, Give	lo		oen, Mexican, Puert	o Rican, etc.)		eck, White, e	
q p		Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Speci	wAfric	an America
Be Completed	15. Decaden (Specify only higher	t's Education st grade completed)	16e. D	ecedent's Usual Occu Give kind of work done fe. DO NOT use retin	petion during most of wor	rking	16b. Kind of I	Business/Indi	ustry
dmi	Elementery/Secondary (0-12)	College (1-4or 5-	+)		9d)				
S	17. Father's Name (First, Middle,	Four Years	Glari	enter	18. Mother's Nan	ne (First, Middle	Privat		lustry
To Be	John L. White	Sr.			Mary P			,	
-	19e. Informant's Name/Relations		19b. N	lalling Address (Stree			per, Clty or Town	n, Stete, Zip (Code)
	Thelma Harris	White		18 35th St					
	20e. Method of Disposition			isposition (Neme of cremetory or other ple		Dete	20c. Location		
	15 Buriar 2 Cremetion 15 Other (S)			1 National		3/1/97	Tours	Mana	-1 A
	21. Signature of Fugreral Service	Ligensee /	THAT Y TALK	22. Name and Addr	ess of Fecility		Laurel		y Land
	23a Party. Enter the disease, or	5. Hunde		Sam Butl	er Funera	al Servi	ice, Inc		DC 20011 Approximete
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edicai	disease or condition	b	Due to (or es a cor	sequence of):	The pra	werit	AS		4 nomby
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DHMH 16 Rev 6/95

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3a or		10e. Street end Number 2201 Hyson Place		10f. Zip Code 2071	5		10g. Citizen of V	Whet Country? d State	e
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I within 72 hours after death with the Marylas lene. then "natural", or frems 23e or 28s-f show the Medical Examiner must be notified at	Completed b	15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12) College (1-4or 5-	+)	Decedent's Usuel Occupi (Give kind of work done of life. DO NOT use retired	etlon during most of word)	king		Whi	
新花香草	Be Co	17. Fether's Neme (First, Middle, Last)	ri.	inter	18. Mother's Nan	ne (First, Middle,	Newpap		
should be nd Mental marked o	ToB	Henry Waak			Sarah (Conrad			
2000年		19e. Informant's Name/Reletionship (Type, Print) John Waak Son		Malling Address (Street)
ges 1 if of He if item or oth		John Waak Son 20a. Method of Disposition 1 □ Burial 2 □ Cremetion 3 □ Removal from Stata 4 □ Donation 5 □ Othar (Specify)	20b. Plece of cemetary	201 Hyson P. Disposition (Name of v. crematory or other place idelis Cemet	е)	Dete 77/97	20c. Location -	715 City or Town, S y Cit y	
permit. Pa Departmen important: any injury once.		21. Signature of Funeral Service Licensee	(me)	22. Name end Addras Robert E. 16000 Anna	es of Facility Evans Fu	neral H	lome, In	с.	
Physician /Medical Examiner	er	resulting in deetil)	o mach	Cancer	y, such as calculate	or respiretory e	irest,	Ons	roximata val Between et and Death
certificate be executed ding physician and se as the burial-transit	/Medical Examiner	if eny, leading to immediate ceuse. Entar Underlying Ceuse (Disease or Injury that letted events of the ceuse in the ceuse of the ceuse in the ceuse of the ceuse	Oue to (or es e co						
death certifi e attending ed for use as	Physician/M	Part II. Other algnificant conditions contributing to death but	t not resulting In	tha undartylng ceuse give	an in Part i.	23b. Did	tobacco use cor	tribute to the	cause of death?
es that the de iigned by the a be detached t	by Phys	Transient Ischemic	4 Hack	ls, Ch-0			Yes 2□ No		4 □Unknown
aw requi	Completed	obstructive Pulmono	e-yD	isease,			en eutopsy rmed?	available	utopsy tindings e prior to ion of ceuse ?
	Be Co	25. Wes cese referred to medical			26. Place of Dee		Yes 2 No	1 🗆 Yes	20 No
Physician: The law requires the this certificate has been signeral director, page 2 should be or	2	exeminer? 1 Yes 2 No Hospitel: 1 Inpatien	t 2 ER/Out		er: 4 🗆 Nursing H	ome 5 Resid	dence 8 Othe		
ath. r: After	Certification:	27. Menner of Deeth 1 Naturel 5 Pending (Month, Day 2 Accident Investigation 3 Suicida 6 Could not be	Year) In	jury Work	ret (? Yes 2 No		how injury occurr		
To the Hospital or Attendin within 24 hours after death. To the Euneral Director: After completely filled in by the fur	i Certif	4 Homicide determined 256. Piece of Injur	(Specify)	m, streel, factory, office		City or To			le Number,
e Hos n 24 ho e Fune detely i	edicai	29a. Certifier (Check only and memory state) Certifying Physician: To the best of and memory state 2 Medical Examinar: On the basis of and memory state	examinetion end	deeth occurred at the tim for Investigation, in my or	e, dete and plece, pinion, death occur	end due to the red et the time,	ceuse(s) end me date end place, a	nner as steted. and due to the o	ause(s)
To the Vithin 2 To the comple	2	29b. Signature and title of certifier	pupping	29c. License	3/00/		29d. Date signed	(Month, Dey, 2/97	Year)
(15)		30. Name end eddress of person who completed cause of des Stuart Turkewitz MD. 31. Dete filed (Month, Day, Year)	eth (Item 23a) (T	Type, Print) 7500	so Green belt,	Md.	C1/1. D	r. #4.	30
Sta Registr	••	31. Dete filed (Month, Day, Year) ADD 09 1007	re Signatura	L. II	. /				

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			5	tate of Maryland / L	Certificate of		ental Hygien Reg. N	9/	08407
	Dhualaí		1. Decedent's Name (First, Middle, Last)			2	. Dete of Death		3. Time of Death
	Physici /Medic			OLVERTON			MARCH 1,	1997	6:25pm.
Ž.	Examir	er	4e. Facility Neme (Il not institution, give street DOCTORS COMMUNITY			4b. City, Town, or Loca		c. County of Death	-000=10 00
_			DOCTORS COMMUNITY 5. Sociel Security Number 6. Sex	HOSPITAL 7. Age (In yrs. last bir.	thdev) II Under 1 Year	LANHAM-SE		PRINCE GE	
L	Funeral Director		579-22-2504	of07 ∈	Yrs. Months Days	Hours Min.	Date of Birth (Month, Dey, Year une 14, 19	918 New	place (Stete or Foreign ntry) York
	yland		10a. State 10b. County	10c. City, Town	n or Location				10d. Inside City Limits
	e Mar	ctor	Maryland Prince Geo	orges Colle	ege Park				1⊠ Yes 2□No
	or 28	Director	10e. Street end Number		10f. Zip Code		10g. C	itizen of What Cour	ntry?
	s 23e	eral	6200 Westchester P			0740		ted State	
21215-0020	72 hours after death with the Maryland natural, or items 23s or 28s-f show steel Examiner must be notified at	by Funeral	1 Never Merried 2 Merried 1	Vas Decedent Ever in U,S. Armed Forces? □ Yes 2⊠ No f Yes, Give Year or Dates:	13. Was Decedent of H II Yes, specify Cube 1 ☐ Yes 2⊠ No	lispenic Origin? (Speci en, Mexicen, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Rece - Americ Black, White, Specify: Whit	etc.
2-0	natural",	ted	15. Decedent's Educatio	n 16a.	Decedent's Usual Occup	ation	16b. I	Kind of Business/In	
121	I within 72 ho liene. Than "natur The Medical.	Completed		College (1-4or 5+)	(Give kind of work done life. DO NOT use retired	during most or working d)			
2		Co	12 17. Father's Name (First, Middle, Last)		Home Maker	18. Mother's Name (n Home	_
Maryland	od late o	o Be	Jack Mancuso					n Sumame)	
ary	S D E E	To	19a. Informant's Name/Reletionship (Type, F	?rint) 19b	. Meiling Address (Street		rancio Route Number, City	or Town, State, Zit	Code)
Σ	nd 2		Vernon Roscoe Wolv	erton (son)]	505 Tucker	Lane, Asht	on Maryla	nd 20861	
ore	ges 1 and of Healt of Healt or other		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Remo	20b. Piece of	Disposition (Name of ry, cremetory or other plea			ocation - City or To	own, Stete
II.	ment ant: h		4 Donation 5 Other (Specify)	Fort I	Lincoln Ceme	tery 3/	5/97 Bre	entwood,	Maryland
Baltimore,	permit. Pages 1 Department of H Important: if the any injury or ot		21. Signeture of Funeral Service Licensee	utiener	Fort Lin 3401 Bla	ss of Facility coln Funer densburg R	al Home,	Inc.	0722
			23a. Part1. Enter the disease, or complication shock, or heart lailure. List only one car	ens that caused the state. Do n					Approximate Intervel Between
1	Physician / /Medical				11	^		0 -	Onset and Death
1	Examiner		Immediate Cause (Final disease or condition resulting in death) a.	Conges	time It	cary to	rilu	4	One Year
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	cate be executed physician and s the bunal-transit	Examiner	Sequentially list conditions	Due to (or as a	consequence of	pains			Que years
00	icate be executed physician and s the burial-transit	EX	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury c.						
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P.0	that the de led by the detached	hys	Part ii. Other significant conditions contribu	ring to death but not resulting in	i the underlying cause giv	en in Paπ I.	1 Yes		o the cause of death?
		by P	Dagell	Mean	9,				
Records,	been s	Completed					24e. Wes en euto performed?	ev	ere autopsy lindings relieble prior to empletion of cause deeth?
	8 4 8	mo					1 ☐ Yes 2	-44	☐ Yes 2☐ No
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of V	Physician: this certific ral director,	10	1 Yes 2 No Hospi	18 Inpatient 2 ER/Ou	tpatient 3 DOA Oth	er: 4 Nursing Home	5 Residence	8 Other (Special	(y)
no	The fact	ion:	1 XNatural 5 ☐ Pending		Time of 28c. Injury Wor		d. Describe how inju	ary occurred	
Division	Attending or death. ector: After by the fune	ficat	2 Accident Investigation 3 Suicide 6 Could not be	Be. Place of injury - At home, fe		Yes 2 □ No	f. Location (Street e	and Number or Rus	al Route Number
<u>S</u>	of in b	Certification:	4 Homicide determined	building, etc. (Specify)	ini, street, ractory, ombo		City or Town, Ster		
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Examinar:	n: To the best of my knowledge On the basis of examination and and manner stated.	, deeth occurred et the tin d/or Investigation, in my o	ne, dete and plece, and plnion, death occurred	d due to the ceuse(s at the time, date an	s) and menner as and piace, and due to	tated. o the ceuse(s)
	To the To the comp	×	29b. Signature and title of certifier	1/	29c. Licens	e number	29d. D	ate signed (Month,	Dey, Year)
			Som	1 ellaw	1 103	142/4	1 3	3.2 -	97
	(10)		30. Name and eddress of person who comple						
			SAM TELLAWI, M.D., 4 31. Date liled (Month, Day, Year)	000 MITCHELLVI	LLE RD., #A	-112, BOWI	E, MD 20	716	
	Sta Registr		MAR 04-1997	32 Registrar's Signature	what!				
			MHU AY 1991	()					

DHMH 16 Rav 6/95

State of Maryland / Department of Health and Mental Hygiene 08408 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Physician Month Vear WILBON HARLES MARCH /Medical 1997 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Deys | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Country) 1**X** M 2□ F Deys Yrs. Director 577-84-0229 52 July 25, 1944 Washington, D.C. Usuai Residence of Deceden 10a. State 10h County 10c. City, Town or Location 10d. inside City Limits 28a-f sh notified Director 1 Yes 2 No Prince Georges Adelphi 10e. Straat and Number 10f. Zip Code 10g. Citizen of What Country? 8 must be 238 1801 Mezerott Rd. Funeral 20783 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lt Yes, specify Cuben, Mexican, Puerto Rican, etc.) Horms 14. Race - American Indian, Black, Whita, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1X Never Married 2 Married Maryland 21215-0020 ö 1 ☐ Yes 2 ☑ No þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Coilega (1-4or 5+) N/A Unemployed 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) ord De ond Mental F Be Calvin Wilbon Mary Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Routa Number, City or Town, State, Zip Coda) nt of Health : Dorothy Moton - Sister 5724 3rd Place N.W. Washington, DC 20011 20b. Piece of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State b 4 ☐ Donetion 5 ☐ Other (Specify) Lincoln Memorial Cemetery 3-7-97 Suitland, MD 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 4217 9th Street N.W. Washington, DC 20011 23e. Part I Entar the diseasa, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseasa or condition rasulting in death) /Medical Examiner Examiner e The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last and to (or as e consequence of): division of Vital Records, P.O. Box 68760, Physician/Medical lax accordent Vascu Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yee 20 No 3 Probably 4 Unknown à Completed 24b. Were autopsy tindings evaliable prior to completion of cause of daath? 24a. Was en eutopsy performed? No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical examiner? Be 28. Piace of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Yes 2 No 1 Dinpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Dascribe how injury occurred After 5 Pending Investigation s after des. death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Piace of Injury - At home, tarm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, daeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signeture end-title of ortifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who complated causa of death (Item 23a) (Type, Print) LULI 10810 Darnestown Rd. Gaithersburg, MD 31. Date filed (Month, Day, Year) Registrar's Signeture State MAR 04 199 Registrar

Barahan Barahan 1911 Sentah

Certificate of Death

Physician
/Medical
Examiner

Funeral Director

28a-f show the Medical Examiner must be notified at 23a or llams : Illad within 72 hours after ò

Saltimore, Maryland 21215-0020 d Hygiene. . Pages 1 and 2 should be 1 tment of Health and Mental tant: If them 27 is marked of 8 permit. Pages 1 and 2: Department of Health at important: If item 27 is any injury or other trau otics.

> **Physician** /Medical Examiner

The law requires that the death certificete be executed certificate or Attending Physician: After this

Box 68760,

Division of Vital Records, P.O.

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fur

1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth February 27,1997 Pauline Delia Wedding 7:20pm 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 7. Age (In yrs. last birthday) If Under 1 Year | It Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) 1□M 21XF Yrs. 215-18-0053 80 April 15,1916 Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 N Yes 2 No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Oliver Street 20782 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Maritei Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herman W. Heuer Della Pauline Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) St. Hyattsville, Maryland 20782 Frances P. Yake -Niece 3907 Oliver 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donetion 5 Dother (♣ 3/3/97 Fort Lincoln Cemetery Brentwood, Maryland 21. Signature d Funeral Service Francis Gascharily Sons Funeral Home, P.A. 4739 Baltimore Avenue Hyattsville, Maryland 23a. Partí. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Ceuse (Final MALLIGNANT VENTRICULAR ARRYTHMA diseese or condition resulting in death) DILATED CONGESTIVE CARDIOMYOPATHY Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last (DIOPATHIC Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? REGURGITATION. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed ONET DIABETES MELLITUS 24a. Was an autopsy 1 Yes 2 No 25. Was cese referred to medicel examiner? Be 26. Place of Deeth (Check only one) 2 1 Yes 2 No 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Day Year) 27. Menner of Death Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medicai 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the ceuse(s) and manner stated. (Check only 29b. Signature end title of cenifier 29c. License number 29d. Date signed (Month, Dey, Year) EBRUARY 27Th, 97 -Asif Qadri 30. Name and address of p ppleted ceuse of deeth (item 23a) (Type, Print) 4700 BERWYN HOUSE PD, COLEEGE PARK MD 2074.0

Jali Saviler Robell

State

Registrar

31. Dete filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth heodore March 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deet BOWIE Drive Georg If Under 1 Year If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) Months Deys Hours 577 44 4783 1 M 2 □ F 60 Yrs April 24,1936 Washington D.C Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's XIN Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 12204 Rustic Hill Drive 20715 United States 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 ☐ No Specify 3 ☐ Widowed 4 ☐ Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) 12 Heavy Equipment Operator Construction 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Leland Wright Helen V. Jewell 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Gladys M. Wright 12204 Rustic Hill Drive Bowie Maryland 20715 Wife 20b. Ptece of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete ¥⊠ Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Dogetion 5 ☐ Other (Specify) Cedar Hill Cemetery March 5, 1997 Suitland Maryland 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart feilure. List only one cause on each line. Approximete Intervet Between Onset end Deeth Immediate Ceuse (Finel · Acute Cononary diseese or condition resulting in deeth) ongesti Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uss contribute to the causs of death? Pulmonary Distas onic obstructive 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evelteble prior to completion of cause of death? 24a. Wes en eutopsy performed? J-17hertenson. 2 5 No 1 Yes 25. Wes case referred to medicat 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpettent 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred

Examiner The lew requires that the death certificate be executed and Division of Vital Records, P.O. Box 68760. physiclan ed by the all

Physician

/Medical

Examiner

Funeral

Director

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must be n

r than "natural", or iten the Medical Examiner.

Hygisne.

Pages 1 and 2 should be fill iment of Health and Mental Hatert if them 27 is marked oth

nt of Health a if them 27 is or other tra

Physician /Medical

8

filled within 72 hours after

Maryland 21215-0020

Baltimore,

Director

Completed by Funeral

1 Naturel

2 Accident

3 ☐ Suictde

29e. Certifier

4 - Homicide

Physician/Medical Be Completed P

Medical Certification:

ate hes been signed by page 2 should be detec this certificate hes ial or Attending Physician: The offer deeth.

Si Director: After this certificate of in by the funeral director, ps Hospital 6

To the Hospital of thin 24 hours of to the Funeral D

State Registrar

29b. Signeture and title of certifier

29c. License number

Fox Lane

1 ☐ Yes 2 ☐ No

28c. Injury et Work?

15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.
2 Madical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, dete end piece, end due to the ceuse(s) end menner steted. 29d. Dete signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name and eddress of person who completed cause

Rakech Aroro 31. Dete filed (Month, Day, Year)

MAR 06 1997

5 Pending Investigation

6 Could not be determined

32 Registrar's Signeture

28e. Ptece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

MAR DE HATE THE STEELER

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene

				Otate	or ivial yland		tificate of		Wellalily	Reg. No.	37	08411
п	Physic	ian	1. Decedent's Neme (First, M	iddle, Last)					2. Date of De Month	Day	Year	3. Time of Death
	/Medi				ANDERSON				MAR	12 199	7	10:44 AM
	Exami	ner	4e. Fecility Name (If not institu	ition, give street end nu	ımber)			4b. City, Town, or	Location of Deal	h 4c. County	of Death	
				NAL NAVAL N	T-				IESDA		ONTGO	
	Funeral Director		5. Sociel Security Number N/A	6. Sex 157 M 2 TF	7. Age (In yrs. la	st birthdey) Yrs.	Months Days		. (Month, D	rth e <i>y, Year)</i> 12, 1997	9. Birthple Count Mary	ece (Stete or Foreign ly) Land
	and *		Usuei Residence of Decedent 10e. State 10b. Cou		10c. City.	Town or Lo	cation				10	Od. Inside City Limits
	Aaryti Faho	5		•			1 71 1 100				10	1 Yes 2 No
	the I	ect	MD Pr	ince George	e Lar	nham	10f. Zip Code			10g. Citizen of	Mhat Count	
	ath with	Funeral Director	4517 Havelock				20706			USA	What Count	iy r
Maryland 21215-0020	be filed within 72 hours efter death with the Maryland that Hyglene. diother than "natural", or flems 23s or 28s-f show event, the Medical Exercines must be notified at	ē	11. Marital Stetus 1 ☑ Never Merried 2 ☐ N 3 ☐ Widowed 4 ☐ Divor	Armed Fo	2 🔯 No ive	11	Vas Decedent of I Yes, specify Cub ☐ Yes 2 No	Hispanic Origin? (pan, Mexicen, Pue Specify:	Specify Yes or Norto Rican, etc.)	Specify	ce - America ck, White, e v: Bla	otc.
5	72 h natu	Completed	15. Dece	dent's Education phest grade complated)		16a. Deced	ent's Usuai Occu	petion during most of w	ntkina	16b. Kind of B	usiness/Ind	ustry
21	ithin	nple	Elementary/Secondary (0-1		1-4or 5+)	life. D	O NOT use retire	during most of wo	Jiking			
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and D	should be filed within and Mental Hygiene. Imarked other than amatic event, the Market than the Market than the Market than the Market than the Market than the Market than Ma	Be	17. Father's Name (First, Midd						me (First, Middle			
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Baltimore,	permit. Pages 1 and Department of Health Important: If Nem 27 any Injury or other ti once.		20a. Method of Disposition	1-2- 1	20b. Ple	ce of Dispos	sition (Neme of letory or other ple	ce)	Date	20c. Location	City or Tov	vn, Stete
E	permit. Pages 1 Department of Inportant: If Ne any Injury or of once.		1 ☐ Burial 2 ☐ Crematic 4 ☑ Donetion 5 ☐ Other	n 3 ∐Removel from (Specify)	State Balt			ton Cr.	3/18	Laure1	, Mar	yland
alti	permit. Pa Departmen Important: any Injury		21. Signature of Funeral Serv		2	22.	Neme end Addre	ess of Fecility				
m	Depariment of the popular in popu			1 ()	· 11 .	10	Fleck Fu	meral Ho	me, Inc.			
	_		23a. Part1. Enter the disease shock, or heart fallure. I	or complications that	caused the deeth.	Do not ente	7601 San	idy Sprin	g Road,	Laurel,	Mary	Land 2070.
L	Physician		shock, or heart failure. I	.lst only one ceuse on a	each line.		ŕ		,			Interval Between Onset and Death
	/Medical		Immediate Cause (Final	7	TRACHEAL	CTENO	CTC					
П	Examiner		disease or condition resulting in death)	a	URSET							
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K 68760,	5 00	Medical	cause (Disease or Injury that initiated events resulting in death) Last	C	Due to (or a	s a consequ	ience of):					
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o.	the a	yslc	Pert II. Other significant cond	itions contributing to d	eath but not result	ing In the un	derlying cause gi	ven in Part I.	23b. Dld	tobacco use co	ntribute to	the cause of death?
<u>α</u>	ras thet the de igned by the a be detached t	by Ph							1 🗆	Yee 2□No	3 Prob	ably 4 Unknown
Vital Records,	aw requi	Completed b							24e. Was perfe	an autopsy ormed?	ava	re autopsy findings llable prior to apletion of cause eath?
R	The la	TO.							1)(1)	Yes 2 No	10	Yes 2⊠ No
Ita	initiate tior, pag	Be	25. Was case referred to med	ical				26. Place of De	ath (Check only	one)		
2,	***	2	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1X	Inpatient 2 E	R/Outpatient	3□ DOA Ott	her: 4 Nursing	Home 5 ☐ Rea	dence 6 Oth	er (Specify))
7	DI		27. Manner of Deeth 1 ☑ Neturel 5 ☐ Per	26a, Date		8b. Time of Injury	28c. Inju Wo	ry at	28d. Describe	how injury occur	red	
<u>A</u>	141	atic	2 ☐ Accident Inve	estigation	,,	,a.ry		Yes 2 □ No				
Divis	1 2 6	#	3 ☐ Sulcide 6 ☐ Cou 4 ☐ Homicide deta	ormined 28e. Place	of Injury - At homing, etc. (Specify)	e, farm, stre	et, fectory, office			Street end Numb wn, Stete)	er or Rural	Route Number,
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	the Hin 24	Medical	ene)	C affinan	ner stated.	II allovot illa	ostigation, in my t	opinion, death occ	uned at the time,	date and place,	and due to	nie cause(s)
	To the vithin 2 To the comple	2	29b. Signature and title of eart	1 1Xm			29c. Licens	se number S-000		29d. Date signe	d (Month, D	ley, Year)
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	2		30. Name and address of pers			3a) (Type, F		ATIONAL I			ENTER	
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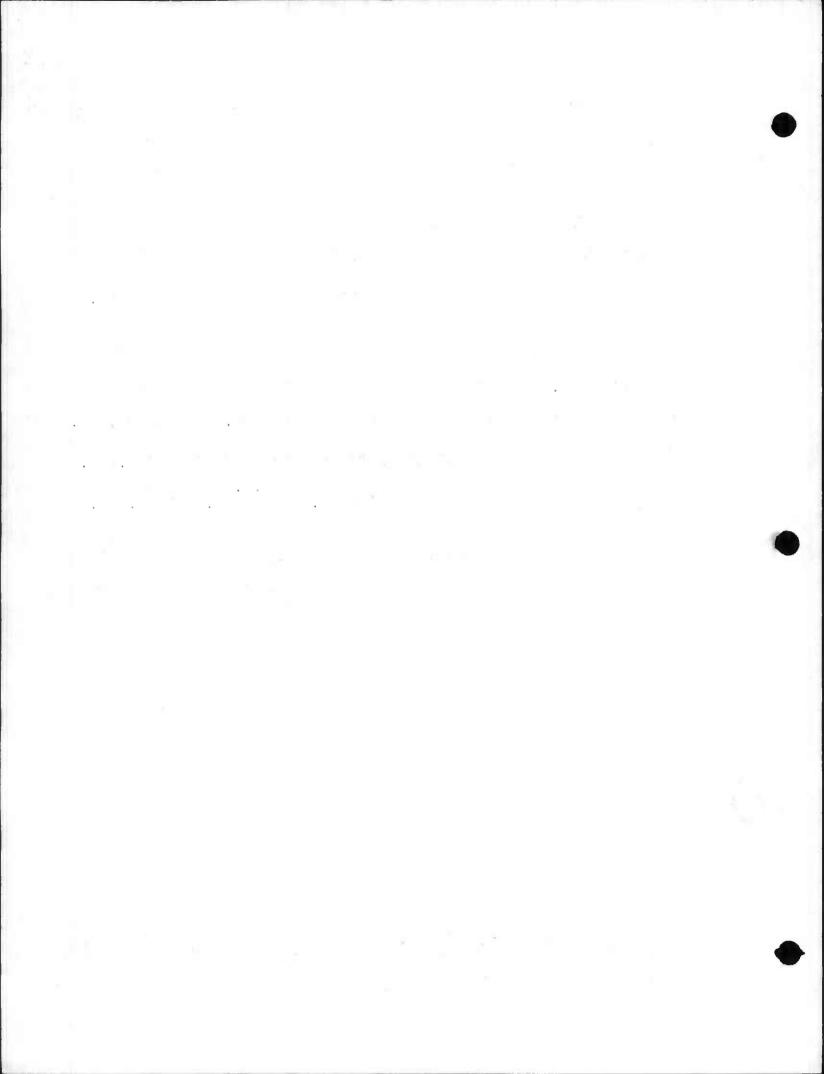
08412 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Defe of Death 3. Time of Deeth **Physician** ORANGIE ALLEN 1997 MARCH 14 12:13 AM /Medicai 4e. Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 1522 GLENEAGLE ROAD BALTIMORE If Under 1 Yeer If Under 24 Hrs.

Months Devs Hours Min. 8. Defe of Birth (Month, Dey, Year) 8 27 4 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Deys 1 ☐ M 2 7 7 X Yrs. Director 218-48-2558 49 MARYLAND Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar mast be notified at Director iX wes 2 □ No N/A MD BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 1522 GLENEAGLE ROAD 21239 US death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes XXNo If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No þ Specify: BLK. 3 Widowed XXDivorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hyglene. Important: if item 27 is marked other than *r any injury or other traumatic event, if a Med 2006. Elementery/Secondery (0-12) College (1-4or 5+) EDUCATION TEACHER 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumema) JUNIOUS T. JONES MILDRED MONK 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) HOLBROOK COHEN 111 1502 FOREST PARK AVE. BALTIOMORE, MD. (SON) 21217 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete XBurial 2 □ Crametion 3 □ Ramovel from Stafe 4 ☐ Donation 5 ☐ Other (Spacify) DRUID RIDGE CEMTERY 3/22/97 BALTIO. MD. 21. Signeture of Funeral Service Licenses 22. Nama and Address of Facility E.L. PHILLIPS F/H PA keln CFSP 1721-27 N. MONROE ST. BALTIO., MD. 21217 23e. Pert I. Enfar the disease, or complications that caused the deeth. Do not enfar the mode of dying, such as cardiac or respiretory arrest, shock, or heer feiture. List only one cause on each line. Approximeta Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disaasa or condition resulting in deeth) **Examiner** Examiner be execute Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest P.O. Box 68760. Physician/Medical 2 Due to (or as e consequence of) 250 95 Par Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? R 1 Yes 2 No 3 Probably 4 Unknown Records, ģ Certification: To Be Completed 24b. Were eutopsy findings avellable prior to completion of ceuse of death? 24a. Was en eutopsy performed? law has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Plece of Daeth (Check only one) exeminer? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division After 1 Naturel 2 Accident Attending 5 Pending Investigation a effection: All at Director: All 1 Yes 2 No 3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 \ Homicide To the Hospital o within 24 hours at To the Funeral Di completely tilled is edical 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only onel 29b. Signetura and fittle of co 29c. Licansa numbar 29d. Date signed (Month, Day, Year) 31. Dete filed (Month, Dey, Year) State

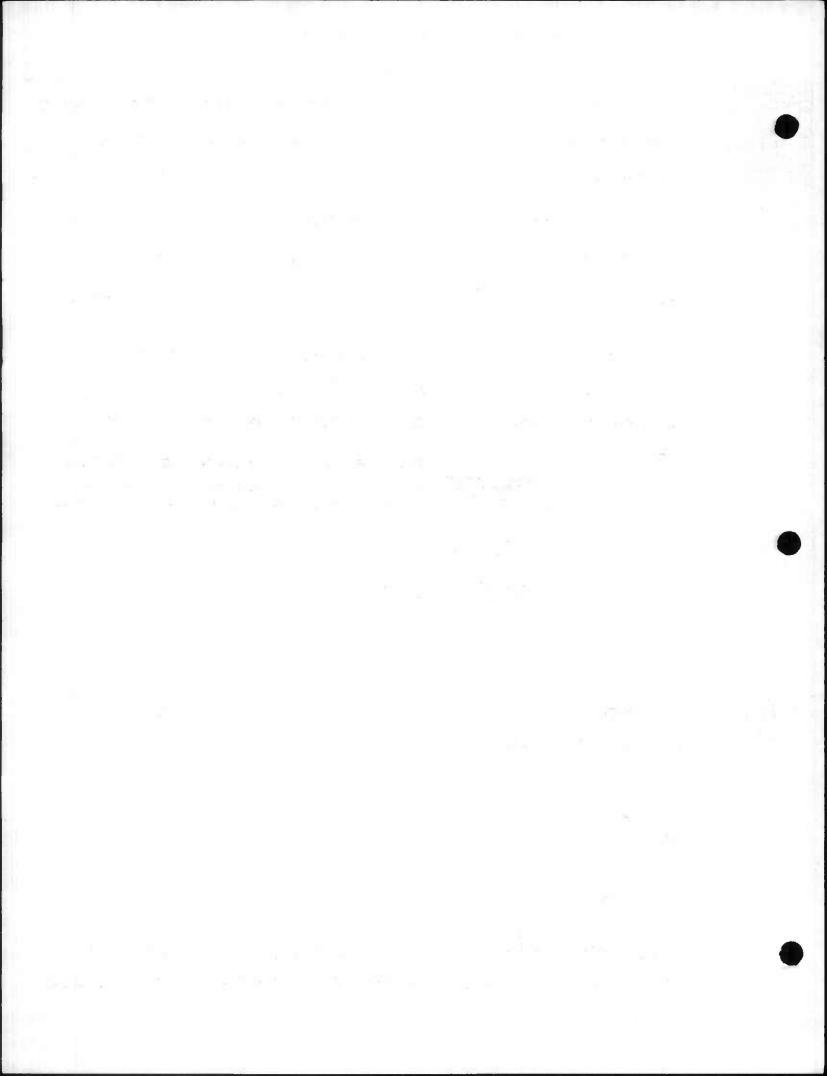
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Registrar

MAR 1 9 1997



		t. Decedant's Nema (First, II	Aiddla Last)		Cer	Certificate of Death			Reg. No. 97 08413			
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death w	Funeral	6304 IVYMOUNT ROAD 11. Marital Status 12. Wes Decedant Evar in						Specify Yes or No-	U.S.A. by Yes or No- 14. Race - American Indian,			
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aryland 2121 should be filed within and Mentel Hyglen e marked other than e umatic evant, tre Me	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) Collaga (1-4or 5+)			16a. Decedant's Usual Occupetion (Give kind of work dona during most of working lifa. DO NOT usa retired)			rking	16b. Kind of Business/Industry			
	o C	12 17. Fethar's Nema (First, Middla, Last)			HOMEMAKER 18. Mothar's Name (Fir.			me (First, Middla, I	OWN HOME rst, Middla, Maidan Sumame)			
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e, h 1 and Health 9m 27 ther tu									MORE, MD 21209			
0 80FP		1 ⊠ Burial 2 □ Cramation 3 □ Ramoval from Stata			Place of Disposition (Name of cematary, cramatory or other place)							
Baltin permit. Pa Departmer Important: any Injury once.		21. Signature of Funeral San		. //	7 //	RE HEBREV Nama and Addre	ss of Facility	3/16/97				
Depariment of the period of th		SOL LEVINSON & BROS., INC. 8900 Reisterstown Road Pikesville, MD 21208										
Physician / Medical pe executed Examiner and Examiner as the prival-transit	1	Causa (Disaase or Injury that initiated events rasulting In death) Last Dua to (or es e consequence of):										
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100	Physician/M	Pert II. Other significant con	sulting In the underlying ceuse given In Part I. 2			23b. Did to	3b. Did tobacco use contributa to the cause of death?					
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ro the within ro the	Mec	29b. Signatura and titla of certifiar			29c. Licansa number			2:	29d. Date signed (Month, Day, Yaar)			
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6		30. Nama and address of per	son who complated co	ouse of death (Its	m 23e) (Type, F	Evel A	re-B	e/husi	t Mr	3 2	1208	
		31. Dete filed (Month, Day, Y	200	. Registrar's Sign	. 11. 7	Roy	della		1			

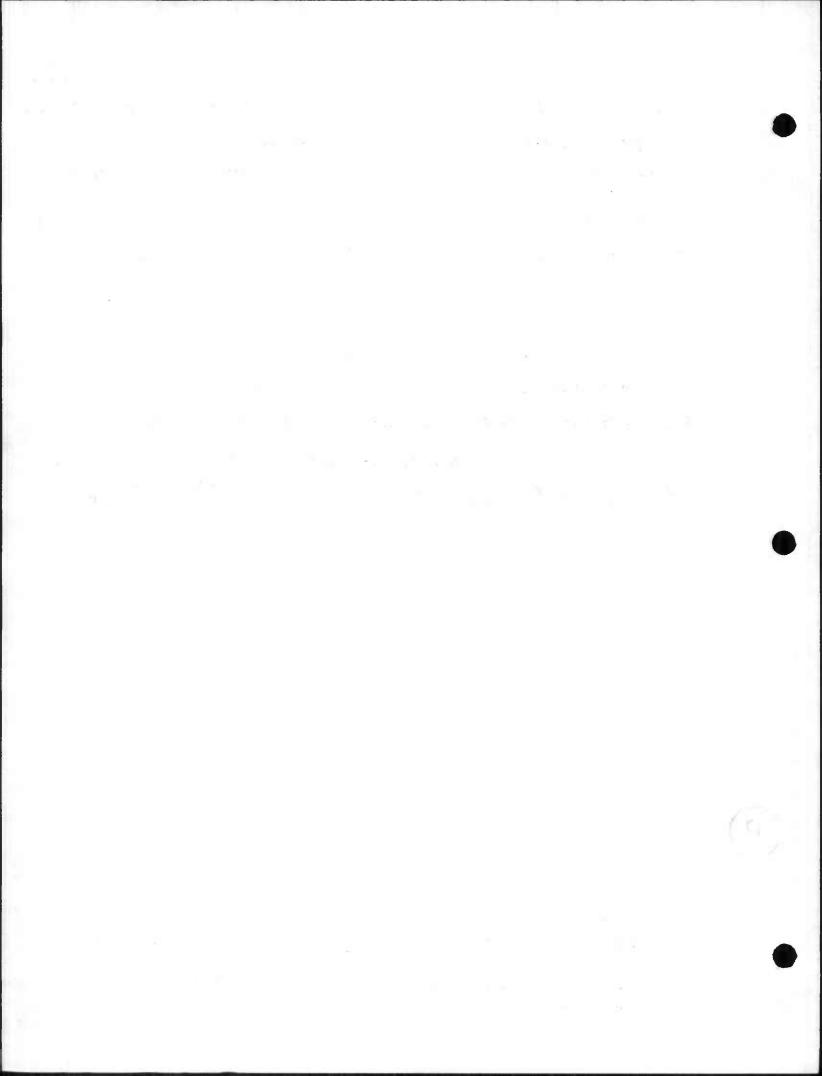


Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** Month Peronne Marie Baker 1997 12:10 p.m. March 18 /Medical 4a. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Visitation Convent TOWSON
If Under 24 Hrs
Hours Min. Baltimore If Under 1 Year 8. Dete of Birth (Month, Dev. Year) December 8, 1914 9. Birthplece (State or Foreign Country)
Pennsylvania 5. Sociel Security Number 7. Age (In yrs. lest birthdey) **Funeral** Deys 1 MX & TYF 173-03-0563 Director 82 Vrs Usual Residence of Decedent the Marylend 10e Stete 10b. County 10c. City, Town or Location show 10d. inside City Limits treumatic event, the Medical Examiner must be nothing at Director 1 Yes 2 No 288-4 Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 234 2300 Dulaney Valley Road 21204 USA Peges 1 and 2 should be filed within 72 hours efter deeth a neat of Health and Mentel Hyglene.
Int: If Hean 27 is marked other than "natural", or itema 23.
Int of other treumatic event, the Medical Earth re-mail riy or other treumatic event, the Medical Earth re-mail. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes X X No if Yes, Give Yeer or Detes: Wes Decedent of Hispanic Orlgin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bieck, White, etc. XX Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes XXXIo specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 18a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) Clerical Religious 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Samuel Chauncey Baker Annie Keefer 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mother Philomena VHM Superior 1500 35th Street NW Washington DC 20007 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Durial 2 Cremetion 3 Removel from State permit. Pege Department of Important: If any injury or once. 4 □ Qonetion 5 □ Other (Specify) 3/21/97 New Cathedral Cemetery Baltimore, Maryland ire of Funeral Service License 22. Neme end Address of Fecility Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** SUSSEN Immediate Ceuse (Finei disease or condition resulting in death) /Medical Acute Myocardial Infarction Examiner Due to (or es e consequence of) Examiner iclan and buriel-transit The lew requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the buriel Records, P.O. Box 68760. Physician/Medicai Due to (or es a consequence of): USB igned by the atter be detached for a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∑ Unknown þ 24a. Wes an autopsy performed? 24b. Were autopsy findings evailable prior to completion of cause of death? Completed has page 2 1 Yes 20 No 1 ☐ Yes 2 ☐ No tificate Vital Be 25. Wes case referred to medical 28. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Convent 1 Yes 2 No Certification: To 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? 1 Netural 2 ☐ Accident 5 Pending 1 Yes 2 No investigation 3 Sulcide 6 Could not be 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) after Direct 4 Homicide A 24 hoses edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end piece, and due to the cause(s) and manner as stated.

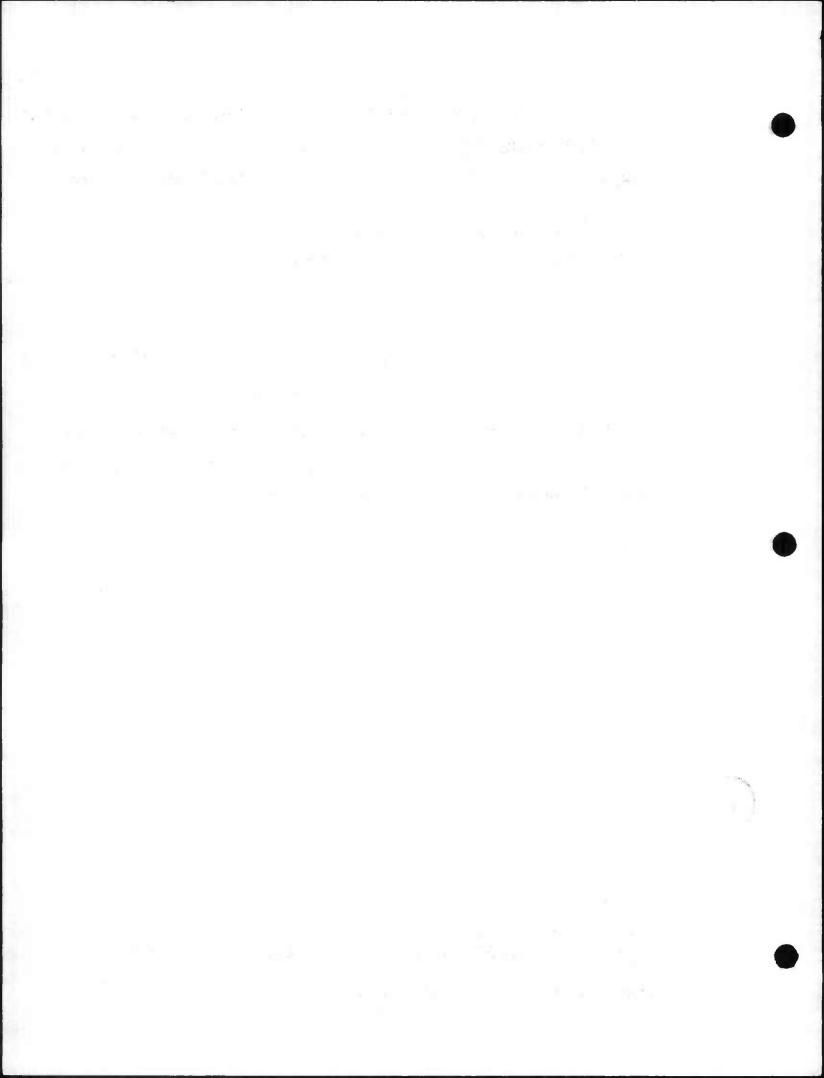
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and menner steted. 29a. Certifie within 24 har To the Fune completely 29b. Signeture and the of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 2/hors 128 3 18. 97 D15504 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Eddie Nakhuda, M.D. 2300 Dulaney Valley Road, Towson, MD 31. Dete filed (Month, Day, Year) MAR 1 9 1997 32. Registrer's Signature

DHMH 16 Rev 6/95

State Registrar



State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physici /Medic Examir	cal	1. Decedent's New 4e. Fecility Nama THE JOH	(If not insi
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8 8	9	11 Marital Status	

permit. Peges 1 and 2 should be filed within 72 hours effer c Department of Heelth and Mental Hygiene. Important if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examines

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

attending physician end for use as the burial-transit this certificate has

Physician: The law requires that the death certificete be executed vision of Vital Records, P.O. Box 68760, To the Hospital within 24 hours To the Funeral

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н	THE JOHNS HO	PKINS HOSP	ITAL				BALTI					n/a		
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	Usual Residence of Decedent	-4.	40. O: T-											
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To Be Completed by Funeral Director	11. Marital Status 1 Never Merried 2 M 3 Widowed 4 Divorce	Armed F larried 1 ☐ Yas	cedent Ever in U,S. orces? 2000 ive Detes:		Was Deced f Yas, spe 1 ☐ Yes	1/ 1/			ecify Yas or N Rican, etc.)	0-		k, White		ACK
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aminer	Sequentially list conditions,	b	Dua to (or es a	40	-5	V	he'	li-	2007			-	+ -	zdr
edical Examiner	Sequentially list conditions, if any, laading to immadiate cause. Entar Undarlying Cause (Disease or Injury that initiated events rasulting In daath) Last	c	Qua to (or as a	conseq	uenca of):	5-	~ia	_					+ 5	Stei
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1 Yas 2 □ No 27. Menner of Deeth 1 A Netural 2 Accident

5 Panding invastigation

6 Could not be determined

1 Inpatient 28a. Dete of Injury (Month, Day Year)

2 ER/Outpatient 3□ DOA 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury et Work?

1 Yes 2 No 28e. Place of Injury - At home, ferm, streat, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

28d. Describe how injury occurred

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the ceuse(s) end menner stated. 29e. Certifier (Check only one) 29b. Signature and title of certifier

3 Sulcide

4 Homlcide

29d. Date signed (Month, Day, Year)

who completed cause of deeth (ttem 23e) (Type, Print)

31 Date Fined (Month, Day, Year)
MAR 1 9 1997 State Registrar

Certification: To

Medical

DHMH 16 Rsv 6/95

Completed Be 2

page certificate After this Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun.

edical

29a, Certifier

29b. Signature

and title of certifier

MAR 1 9 1997

Division of Vital

Attending

25. Was cese referred to medicel 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 1 Inpetient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 3-9-97 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Pending investigation Injury Unk 1 Neturel 1 Yes 2 X No Unknown 2 Accident Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

Home 10500 Brandywine Rd, Clinton, MD

1 Certifying Phyaician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) end manner steted.

29c. License number

O.C.M.E.

3. Time of Deeth

Birthplace (State or Foreign Country)

Washington, D.C.

Approximete Intervei Betw

24b. Were eutopsy findings eveileble prior to

29d. Date signed (Month, Day, Year)

MARCH 17, 1997

eveileble prior to completion of cause of deeth?

10d. Inside City Limits

1X Yes 2 No

4:40 PM

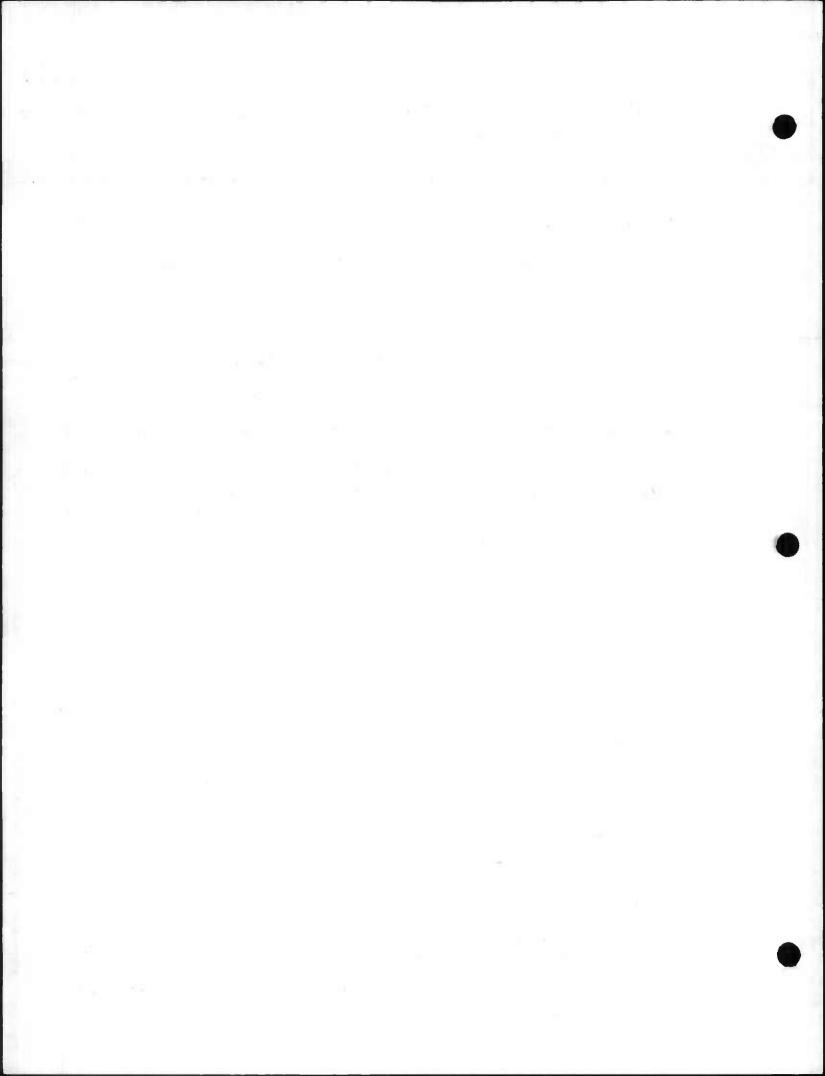
Year

and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 Laron Locke M.D. 31. Dete filed (Month, Dey, Year)

State Registrar

32 Registrer's Signeture Randelle ina Davidson

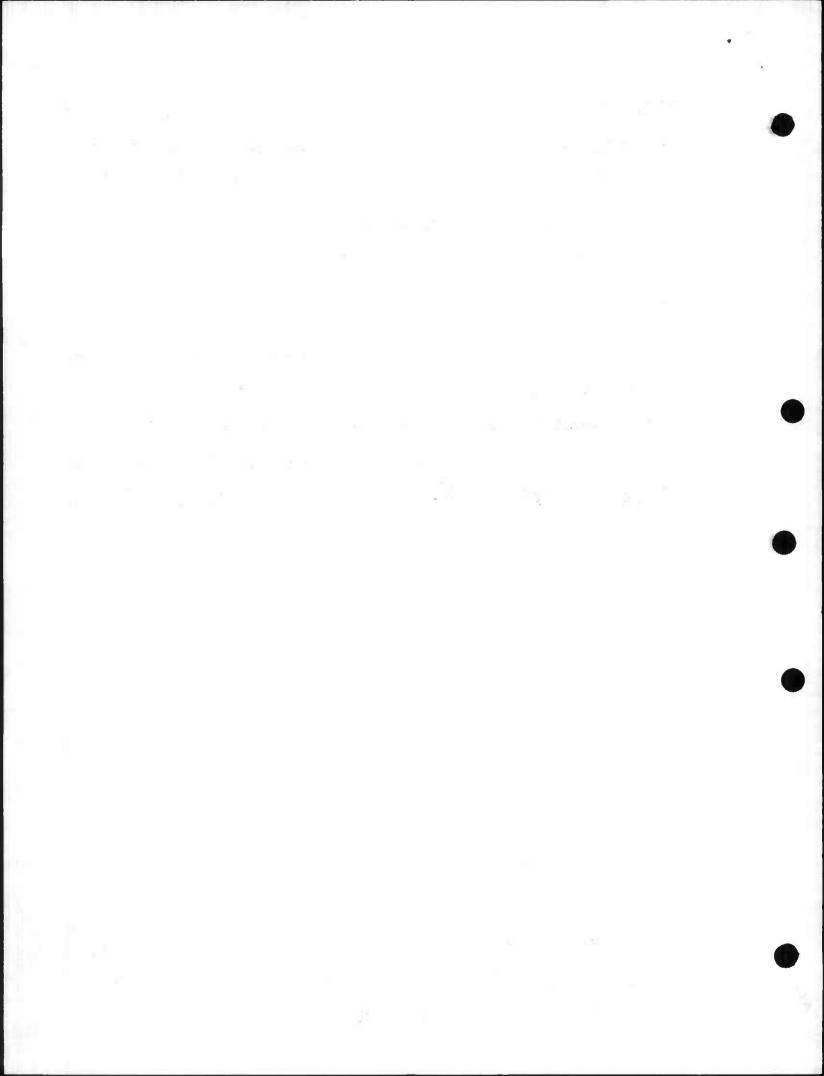


		Item 26,27 per PHY Fill 1. Decadent's Name (First, Middle, Las		rja <i>Cel</i>	rtificate of			giene Reg. No.	7 08418
Physici /Medi	cal	Robert E. Bul	hs				2. Date of De Month March	8, Day 1997	
Examir	ner	4a. Facility Name (If not institution, give 2608 Poplar Dri				4b. City, Town, or Woodla			eath imore
Funeral Director		5. Social Sacurity Number 6. Se		rs. lest birthday) Yrs.	If Under 1 Year Months Days		8. Data of Bir		Birthplace (Stata or Foreigr Country)
		Usual Rasidence of Decedent 10a. State 10b. County		Oh. T					
n the Maryland r 28a-1 show	5	MD. Baltimo		City, Town or Lo Voodlav					10d. inside City Limits 1 ☐ Yes 2 ☒ No
or 28a-	rect	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
th w	a D	2608 Poplar Dri	ive		212	07		U.S	. A .
or Ite	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of H f Yas, specify Cub 1 ☐ Yes 2 ☐ No		Specify Yes or No to Rican, etc.)	14. Race - A Black, W Specify: W	merican indian, Thite, atc. hite
natural,	ted	15. Decedent's Edi (Specify only highest grad		16a. Deced	lent's Usual Occup	pation	orkina	16b. Kind of Busine	ess/Industry
	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Draft	kind of work done DO NOT use retire	d) most of we	лкид	Lever B:	rothers
should be filed within nd Mental Hygiene. marked other than umatic event, or M.	To Be C	17. Father's Neme (First, Middle, Last) Edmond Buhs					me (First, Middle	Maidan Sumama)	
d 2 sho th end N 7 is ma trauma		19e. informent's Name/Reletionship (7) Shirley Buhs/						er, City or Town, Stet	
permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, traumone.		20a. Method of Disposition 1 Burial 2 PCremation 3 4 Donetion 5 Other (Specify,	Removal from State	. Placa of Dispo cematery, crem	sition (Neme of netory or other ple	ca)	Data	20c. Location - City	
pemit. Page Depertment Important: If any injury or once.		21. Signature of Funaral Sarvice Licans						al Home, Lto., MD	
cote be executed physician and and sthe buriel-transit	Examiner	disaase or condition resulting in daath) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. ———	(or as a conseq	uence of):	forc	HO I		
5 00	8	Cause (Disease or injury thet initiated events resulting In death) Last	Dua to	(or as a consequ	uence of):				
atte	Physician/M	Part II. Other significant conditions con	ntributing to death but not re	esulting In the ur	nderlying cause giv	ven in Part I.	23b. Dld	tobacco use contrib	ute to the cause of death
9 9							10	Yes 2□ No 3□	Probably 4 Unknow
that the cled by the deteched	5								
requires that the c	pleted by						24a. Was	an autopsy 24 med?	b. Were sutopsy findings available prior to completion of cause of death?
The law requires that the cate has been signed by the page 2 should be deteched	Completed by						24a. Was perfo	med?	avaliable prior to completion of cause
The law requires that the cate has been signed by the page 2 should be deteched	Be Completed	25. Was case referred to medical examiner?	Hospital:		Ott	oer.	perfo	Yes 20 No	available prior to completion of cause of death? 1 Yes 2 No
sing Physician: The iaw requires that the c. h. After this certificate has been signed by the funeral director, page 2 should be deteched	To Be Completed	examiner? 1 Yas 2 No 27. Menner of Deeth 1 Naturaf 5 Panding	Hospitai: 1 ☐ Inpatiant 2 [28e. Dete of injury (Month, Dey Year)	□ ER/Outpatien 28b. Tima of Injury	28c. inju	ner: 4 Nursing I	ath (Check only of	Yes 2 No	available prior to completion of cause of death? 1 Yes 2 No
Attending Physician: The law requires that the cardath. erchalt. ercor After this certificate has been signed by the by the funeral director, page 2 should be deteched.	To Be Completed	examiner? 1 Yas 2 No 27. Menner of Deeth 1 Natural 5 Panding	28e. Dete of injury	28b. Tima of Injury	28c. injus Wor M 1	ner: 4 Nursing I ny at nk?	ath (Check only of Homa 5 Sest	Yes 2 No No one) dence 6 Other (5 how injury occurred	available prior to completion of cause of death? 1 Yes 2 No
Attending Physician: The law requires that the cardath. erchalt. ercor After this certificate has been signed by the by the funeral director, page 2 should be deteched.	Certification: To Be Completed	examiner? 1 Yas 2 No 27. Menner of Deeth 1 Naturaf 5 Pending investigation 3 Sulcida 6 Could not be determined 29a. Certifler 12 Certifying Physical Country (1998)	28e. Dete of injury (Month, Dey Year) 28e. Piece of injury - At	28b. Tima of Injury home, farm, streety)	28c. injun Woo M 1 Deet, factory, office	ner: 4 Nursing In the results of the	ath (Check only of Homa 5 Describe 28d. Describe 28f. Location (City or Total)	Yes 2 No one) dence 6 □Other (S how injury occurred Street end Number or vn, Stele)	available prior to completion of cause of death? 1 Yes 2 No Specify) Rural Route Number,
or Attending Physician: The law requires that the c Bifectors After this certificate hes been signed by the In by the funeral director, page 2 should be deteched	To Be Completed	examiner? 1	28e. Dete of injury (Month, Dey Year) 28e. Piece of injury - At building, etc. (Specialization of the best of my kniner: On the basis of examin	28b. Tima of Injury home, farm, streety)	28c. injun Woo M 1 Deet, factory, office	ner: 4 Nursing I y at rk? Yes 2 No me, dete and place	ath (Check only of Homa 5 See See See See See See See See See S	Yes 2 No one) dence 6 □Other (S how injury occurred Street end Number or vn, Stele)	available prior to completion of cause of death? 1 Yes 2 No Repecify) Rural Route Number, as steted. due to the cause(s)
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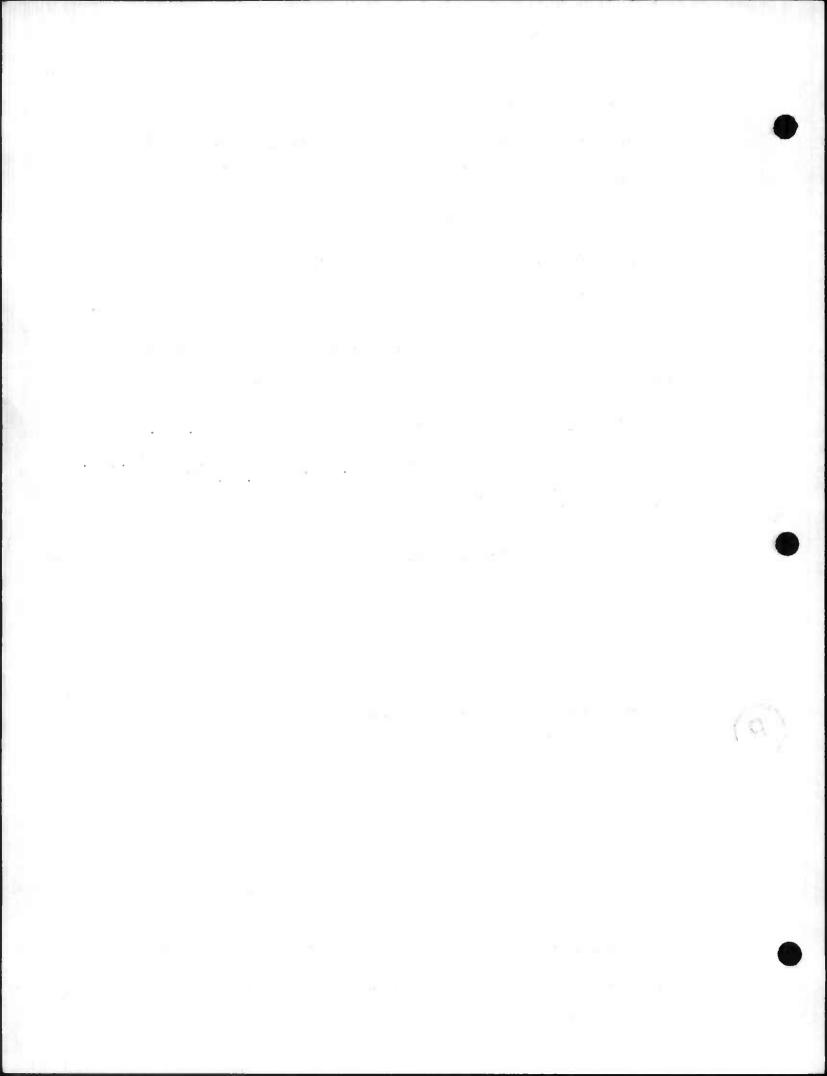
DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene

						Cei	rtificate	of L	Death		Reg. No.	m. f	00115
- L			1. Decedent's Name (First, Middle, La			4 .0				2. Date of D			3. Time f = th
	ysiciar Iedica		MARGARET		ONR	AD				MARCH	Day	1997	0725
	iledica amine	_	4a. Facility Name (If not institution, give					4	b. City, Town, or	Location of Dea		ity of Death	
		1	7754 Notley Rd.						D1.	301			
-		-	5. Social Security Number 6. S	ex 7. An	e (h vrs k	est birthday)	If Under 1	Year	Pasade If Under 24 Hrs	na S. R. Date of B.	Anne	Arun	
Fune Direc	_	П		□M 2気F		Yrs.	Months	Days	Hours Min	8. Date of B	ley, Year)		place (Stete or Foreig
Direc	.101	1	Usual Residence of Decedent		70					Mar 29	, 1926	Penn	sylvania
end w		1	10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
Aary	2 3	5											1 ☐ Yes 2 ☑ No
9 8	be notified	2	Maryland Baltimo	ore	I	Pikesv							
with the Marylen	2 2	5					10f. Zip (>008			10g. Citizen o	What Cou	intry?
death with the Marylend ms 23a or 28a-f show		a	711 Cloudyfold D					2120			USA		
20 efter dea or itams	De Medicel Examiner must	runeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever In U.S	S. 13. \	Was Decede f Yes, specif	int of Hi fy Cuba	spanic Origin? (S n, Mexican, Puer	Specify Yes or Nation Rican, etc.)	lo- 14. R B	ace - Ameri lack, White	ican Indian, . etc.
Taryland 21215-0020 2 should be filed within 72 hours efter end Mental Hygiene.			1 Never Married 2 Married	1 Tyes 2 🖸 I	No		1□ Yes 2		Specify:		Spec		, 6.6.
aryland 21215-0020 should be filed within 72 hours eft and Mental Hygiene.	4	200	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:					орозиј		Spec	Wh.	ite
5-1 72 h		Completed	15. Decedent's Ed (Specify only highest gre	lucation		16e. Deced	dent's Usual	Occupa	ation furing most of wo)	orkina	16b. Kind of	Business/Ir	ndustry
within ene.		ď.	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. L	DO NOT use	retired)	nnig	Hech	t Co.	
filed with Hygiene. ther than		0	12 years			Retai	1/Adm	ini	strative		Depart	ment	Store
should be filed nd Mental Hygi marked other	Evant De G		17. Father'a Name (First, Middle, Last)						18. Mother'a Na	me (First, Middle			
lenta ked	TO E	0	George	Mergo					Susan	Unknown			
Should N	traumatic avant,	-	19a. Informant's Name/Relationship (19b. Mailin	no Address /	Street e		lural Route Numi		m. Stete. Zi	in Code)
PAR			Donald D. Connad	T (C	\								,
- T 5 1	other.	-	Donald R. Conrad 20a. Method of Disposition	Jr. (Son	20h Pl	aca of Dispo	Notle	e of		adena,	20c. Location	122	own State
0-2			1⊠ Burial 2 ☐ Cremation 3 ☐		CE	metery, cren	netory or oth	ner plec	B)			it - Oily or 1	Own, State
permit. Page Department of Important: If	E C		4 □ Donation 5 □ Other (Specify		Mor	eland	Memor	ial	Park	3-17-97	Parkv	ille,	Maryland
ade Local	DCB.		21. Signature of Funeral Service Licen	S00	1		. Name and			1 Dd		т.	
205	2 G		John K	Skynil	~		the state of the s	-		al Dire			21122
			23a Part Enter the disease, or comport or heart fallure. List only	plications that caused	the death	. Do not ente	er the mode	of dyln	, such as cardia	Randall c or respiretory	SEQWIL.	rii)	21133 Approximate
Physici	ian		shock, or near failure. List only	one cause on eech III	ne.							į	Interval Between Onset and Death
/Medi			Immediate Cause (Finel	CAL	201	2121		40	1 1	1110			C
Exami	ner		disease or condition resulting in deeth)	a. CAI				01	- 1	100			6 MONTH.
	— 2	5			Due to (or	as a conseq	uence of):					i	
	T xaminer		20	b									
and		Y	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Due to (or	as a conseq	uence of):					i	
ician be			cause. Enter Underlying Cause (Disease or Injury	c									
ding physician and	as me bu	5	that Initiated events resulting In death) Last		Due to (or	as e conseq	uence of):						
certificate be executed ding physician and	Se as	E	L.	d								i	
	Su ve	2	_	u									
within 24 hours all or death. To the Fundament Director. After the confliction has been signed by the advantage of the confliction has been signed by the advantage of the confliction has been about the confliction of the confliction has been advantaged for the confliction of th	0	2	Part II. Other significant conditions or	ontributing to death be	ut not resu	Iting in the ur	nderlying car	use give	n in Part I.	23b. Dic	tobacco use	ontribute	to the cause of death
been signed by the atten	Physician									1)2	Yes 2 No	3 Pro	bably 4 Unknow
Deug	2									- 1			
S Ce										24a. Wa	s an autopsy formed?	24b. W	ere autopsy findings vallable prior to
										pen	omeur	C	ompletion of cause
2 9	Com									40	Yes 2 No		
certificate	i C		OF Management to a state of								1111	1	Yes 25 No
certif	olractor,		25. Was case referred to medical examiner?	Hospital:				Othe	MP1	ath (Check only			
this	-		1 Yes 2 No	1 L Inpatie		R/Outpatien			4 LI Nursing i	Home 5 Res			ify)
After After		5	1 DNatural 5 Pending	28a. Date of Inju	Year)	28b. Time of Injury		c. Injury Work		28d. Describe	how Injury occ	urred	
oc.	ten ten		2 Accident Investigation				М	1 🗆 '	/es 2 □ No				
100	6		3 Sulcide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At hor	me, farm, stre	eet, factory,	office			(Street and Nur own, Stete)	nber or Rui	ral Route Number,
200	Certification:	5											
within 24 hours after o To the Funeral Direct	180	3	29e. Certifiler 1 Certifying Phy (Check only 2 Medical Exam	yelcian: To the best of	of my know	ledge, death	occurred at	the tim	e, date and plac	e, end due to the	ceuse(s) and	manner as	stated.
within 24 hours after death To the Funeral Director: A	edical	3	one) 2 Medical Exam	iner: On the basis of and manner sta	examination ted.	on and/or inv	estigation, i	n my op	inion, death occ	urred at the time	, date and place	e, and due i	to the cause(s)
000		-	29b. Signature and title of certifler						number		29d. Date sign		
			P. C. New	mo				D 3	37333	3	MARC	4 11	+,1997
		-	30. Name and address of person who		nath /ltom	23a) /Time !							, ,
0			C. RAVI Mr.) , 9017	LIP	ERY	RD	RA	LTIMA	RE N	1021	133	
	CALL		31. Date filed (Month, Dey, Year)	32 Bonister	r's Signati	UTA I	/	1011	-, , , , ,	1			
	State		MAD 1 Q 1	32. Registy	lia A	1	Birdage.						



				State of	Marylan		artment rtificate			and M	lental Hy	giene Reg. No.	97	081	20
Physicia		1. Decedant's Nama (First, Mi		•						П	2. Data of De Month March		Year 1997		of Death
/Medica Examine		4a. Facility Nama (If not institu	tion, giva	street and numb	er)						ocation of Deeti		ty of Death		P.M
Funeral Director		5. Social Security Number 212-10-4094 Usual Rasidance of Dacedant	6. Sa	ax 7. ZM 2□F	Aga (In yrs. 87	last birthday) Yrs.	If Under Months	1 Year Days	If Undar Hours		8. Date of Bir (Month, Da	th	9. Birth	npiece (Stets intry) RYANI	or Foraign
r 28a-f show	tor	10e. Stata 10b. Cou	nty /A			y, Town or Lo								10d. Inside	City Limits
or 28s	Director	10e. Street and Number					10f. Zip	Coda			141	10g. Citizan o	f What Cou	intry?	
urs aftar daath v al', or iterns 23s	by Funeral	911 WICKLOW 11. Marital Status 1 Navar Married XX 3 Widowed 4 Divord	arried	12. Was Daceda Armed Forca 1 Yes if Yas, Give Year or Deta	as? ∑No					gin? (Sp i, Puarto	ecify Yas or No Rican, etc.)	US 14. Ri Bi	ack, winta		
d within 72 jiena. r than "nat	Completed	15. Daced (Specify only hig Elamantary/Secondary (0-12	hast grad	ucetion de com <i>pleted)</i> Collega (1-4-	or 5+)	(Giva lifa.	dant's Usual kind of work DO NOT use	k done a retired	<i>during</i> mosi <i>d)</i>	t of work	ing	16b. Kind of			5
be file tal Hy d oth	To Be C	17. Fathar's Nama (First, Midd	la, Last) LBUR			,			18. Mothe REB		a (First, Middla, A	, Maidan Suma HA			
permit. Pagas 1 and 2 sh Department of Haaths end Important: If Itam 27 Is m any Injury or other traum once.		19a. Informant's Name/Relatic EMILY COLBUJ 20a. Method of Disposition 1XXurial 2 Cramatic 4 Donation 5 Other 21. Signature of Funaral Servi	RN n 3 □F (Specify)	(WIFE) Ramoval from Sta	AE	911 Place of Disponentary, crail	WICK pstilon (Nam matory or of	LOW	ROA	D 3	BALTIC Data /21/97 . J. P	20c Location BALT	212 - City or 1	29 own, Stata	L Hom
Physician		23a. Part1. Enter tha disaasa, shock, or haart failura.	or comp ist only o	CF CE CALLER CAUSE ON ARC		h. Do not an	tar tha moda	a of dyin	ng, such as	cerdiac	or raspiratory a	rrast,	ORE, A	Approximintarvai B. Onsat and	ata atween
/Medicai Examiner	-	Immediata Causa (Final disaase or condition resulting in death)		a. PULMO		EMBOLI or as a consec	quance of):						1	10 da	ys
certificate be axecuted ding physician and use as the buriel-transit	i Examiner	Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury	5	b	Dua to (o	r as a consec	quance of):								Н
5 P	n/Medical	that initiated avants rasulting in daath) Last	l	d	Dua to (o	r as a consec	juance of):								
death e attan	Physician/M	Part II. Other significant cond	itions co	ntributing to deat	h but not ras	ulting in tha u	ndarlying ce	usa giv	an in Part I		23b. Did	tobecco use o	ontribute	to the cause	of death
A CONTROL	by Pny	Cardiac hyp			ondar	y to c	alcif	ic		·	10	Yes 2 No	3 □ Pro	obably 4[Unknow
has be should	Completed	aortic sten	osis	•					_		perfo	an autopsy ormad?	a	Vare autops; veilable prio omplation of f daeth?	rto
cartificate the rector, page											10	Yas 2□No	1	Yes 2	□ No
Physician:	10 56	25. Was cesa rafarred to medi axaminar? 1 ☐ Yas 2 ☐ No		Hospitai:	atiant 2 🗆	ER/Outpatiar	nt 3 DO	A Oth	or:		h <i>(Check</i> on <i>ly o</i> oma 5 ☐ Rasi		thar (Spec	ifv)	
Attending Ph r death. ector: After Ihi by the funeral		27. Mannar of Death 1 Natural 5 Pan 2 Accidant inva 3 Suicida 6 Cou	stigation	28a. Data of I (Month,	njury Day Year)	28b. Tima o Injury	f 28	Bc. Injur Wor 1 🗆		No	28d. Dascribe	how injury occ	urred		
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After complately filled in by the funer		4 ☐ Homleida data	rminad		atc. (Specify	y)					28f. Location (City or To	wn, Stata)			m <i>ber</i> ,
within 24 hours To the Funeral complately filled	edical	(Check only 2 Medic	ai Exami	sician: To tha ba ner: On tha besis and mannar	s of axamina	tion and/or in	vastigation,	in my o	pinion, daa	th occuri	rad et tha time,	date and place	e, and dua	to tha causa	(S)
within To th		29b. Signatura end title of cart		292u	cken	On I	29c.		a number)4964			29d. Date sign			
10		30. Nama and addrass of personal William J.						ital	900		ton Asset				D 211
State • Registra		31. Data filed (Month, Day, Year MAR 1 9 19	97)	ø32. Hagi	strar's Signa	tura	_nosp.	4101	.,	_ual	TOIL AVE	uue,Da	TUTING	ore, M	U-212



State of Ma

aryland /	Department	Of	Health	and	Mental	Hygie
	Cartificate	4	D41			

0.7	0010
97	0842

Physician	
/Medical	
Examiner	

Funeral Director

28a-f show nothing at 8 maint be itema 23a 72 hours aftar 8 "natural". The Medical se filed within 7 sel Hygiane. d other than "n Pages 1 end 2 should be file ment of Health end Mentel Hi lant: If Itam 27 is merked oth

Baltimore, Maryland 21215-0020

Box 68760

P.O. |

Records,

Division of Vital

Physician /Medical Examiner

and physicien the for use es the signed by 2 ate has certificate this After Director: d in by the

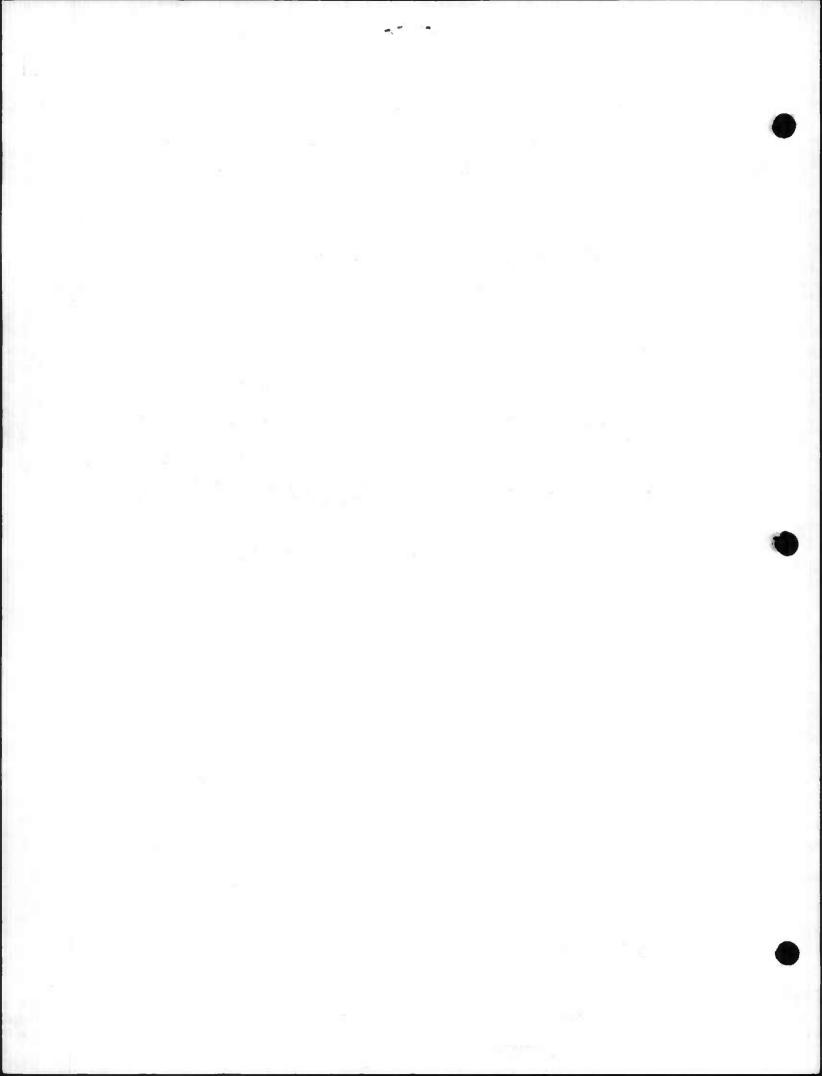
The law requires that the death certificate be executed or Attending Physician: aftar deeth. Hospital To the Hospital within 24 hours a To the Funeral Completely filled

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 1997 6, ANTONIO CURTIS MARCH 03:42 Am 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth SHOCK TRAUMA UNIT BALTIMORE N.A. 6. Sex, 1∰M 2□ F 5. Social Securify Number If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 2/25/79 9. Birthplece (State or Foreign Country)
MD. 7. Age (In yrs. lest birthday) Months Deys Hours 18 Vrs 217-92-4302 Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director BALTO. CITY BALTIMORE MD. 10e. Street end Number 10f. Zlp Code 10g. Citizen of Whet Country? LAKEWOOD AVE. 21205 816 N. USA Funeral 14. Rece - American Indian, Bleck, Whife, etc. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Sfefus 1 Yes 2 No If Yes, Give Year or Detes: **AFRO** ₩ Never Married 2 Merried 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify: AMERICAN Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) NONE None 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) TONY CURTIS MAMELA ATKINS 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s Depertment of Health er Important: If Itam 27 is any Injury or other trau 816 N. LAKEWOOD AVE. BALTO. MD. 21205 TONY CURTIS FATHER 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) MT. ZION 2/11/97 LANSDOWNE, MD. 22. Name end Address of Fecility
ESTEP BROTHERS FUNERAL HOME P.A. neral Service Licenses 1300 EUTAW PL. BALTO. MD. 21217 Enter the Usease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. Approximete Interval Rety Onset end Deeth Immediete Ceuse (Finel disease or condition resulting in deeth) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) examiner? 1 4 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 10 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Medical Certification: 28e. Date of Injury (Month, Day Year) 5 Pending Investigation 1 Naturel 1 Yes 2 No Subreci 3/6/97 2 Accident 281. Location (Street and Number of Rural Route Number, City or Town, State) z 700 BLock East Midson 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Street 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signeture end fitte of certifier 29c. License number 29d. Dete signed (Month, Day, Year) MARCH 6, 1997 OCME 30. Name and address of person who completed cause of dear them 23e) (Type, Print) I HEUDORE MIKE 111 Penn Street, Baltimore, Maryland 21201 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture

State Registrar

MAR 1 9 1997

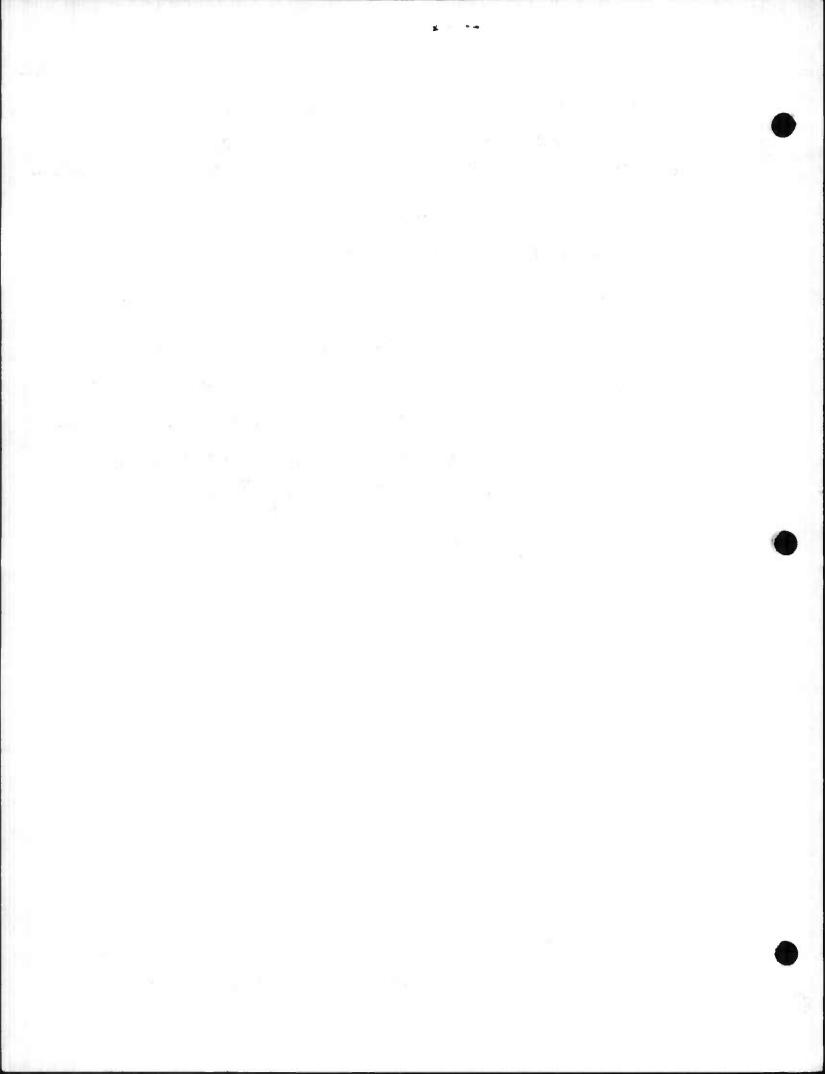


L					d / Depa		Health and No. 1	Mental Hyg	giene	0.7	18422
	Physici /Medi Examir	cal	1. Decedent's Neme (First, Middle, Last) ALTON A. 4e. Fecility Neme (If not institution, give street end number) 3600 W.FRANKLIN STREE'	T		COPELA	ND SR. 4b. City, Town, or L	2. Dete of Dee Month MARCH ocation of Deeth	Dey	Yeer 3.	Time of Deeth
	Funeral Director			e (In yrs. k	ast birthday) Yrs.	If Under 1 Year Months Deys		8. Dele of Birth	327	9. Birthplace BALTIM	(State or Foreign
	72 hours after death with the Maryland natural', or items 23a or 28a-f show picel Exammet must be notified at	Director	10e. Stete 10b. County MARYLAND		TIMORE	Ξ,				1	nside City Limits
	death with the 23a or 2	Funeral Dire	11. Marital Slatus 12. Was Decedent	APT 9		10f. Zip Code 21229 Ves Decedent of	Hispenic Origin? (Sp		USA 14. Rec	Whet Country?	dien,
0020	d within 72 hours after death with the Marylan jiena. r than "natural", or items 23s or 28s-f show The Medical Express results on ordined at	þ	1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Give Yeer or Detes:		17 1	□ Yes 2 No			Specify	CAFRO.AI	MERICAN
21215-0020	d within piena. r than "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5	i+)	IIIe. L	lent's Usuel Occu kind of work done DO NOT use retire CK DRIVE		king	BRANCH	usiness/Industr	4
Maryland	wild be file Mental Hygarked othe arked othe	To Be C	17. Fether's Name (First, Middle, Last) ALTON L. COPELAND					CPPELAND)		
	d 2 s th ar trau		19a. Informent's Neme/Relationship (Type, Print) HORTENSE WILLIAM 20e. Method of Disposition	20b. Pl	3332		E STREET,	BALTIMO		LAND 2	1215
Baltimore,	permit. Pagas 1 an Department of Heal Important: If Item 2 any injury or other once.		1 M Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Deensee		RRISON	FOREST			OWINGS	MILL, N	MD.
	Physician /Medicai		23a. Pert1. Enter the disease, or complications that caused shock, or heart fellule. List only one cause on each little disease or condition		. Do not ente	er the mode of dy		or respiratory err	rest,	App	roximete rvel Between set end Deeth
Box 68760,	death certificate be assecuted as ettending physician and idea as the burial-transit as	√Medical Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury	Due to (or	es e conseques es e conseques	uence of):	00 V-3 CW (V	VC(3	ews		
P.O. B	tha c	Physician/Medi	Pert II. Other significant conditions contributing to death by			nderlying cause gi	iven in Pert I.	1000	obacco use co	ntribute to the	cause of death?
of Vital Records,	e law requiras has been sign ja 2 should be	Completed by	Fally hiver hastrointestral hen	orrh	use			- 11	med?	eveilebl comple of deeth	
ta	cartificate h	Be Co	25. Wes case referred to medical				26. Plece of Deal		es 2 No	1 Yes	2 □ No
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Division o	if or Attanding P after daeth. I Director: After t d in by tha funar	Certification:	27. Menner of Deeth 1 Meturel 5 Pending investigation 3 Suicide 6 Could not be determined	Yeer)	28b. Time of Injury me, farm, stre]Yes 2□No	28d. Describe he			ite Number,
Ö	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this cartific complately filled in by the funeral director.	edical Cert	29a. Certifier (Check only) Certifying Physician: To the best of the desired to	of my know examineti	vledge, deeth				euse(s) end me		
	To the within 2 To the complete	Med	29b. Signeture end title of certifier	ted.		29c. Licen	se number		9d. Date signe		Yeer)
	7 Sta	te.	30. Name and eddress of person who completed cause of de limit of the completed cause of the cause of the completed cause of the completed cause of the completed cause of the completed cause of the cause of the completed cause of the cause of the cause of the cause of the cause of the	111	Penn	Print)	, Balti	more, N			

State Registrar

MAR 1 9 1997





Nuler

State Registrar

31. Dete filed (Month, Dey, Year)

MAR 1 9 1997

32. Registrer's Signature

Ship Javidson-Rando

me and address ot person why completed cause of death (Itam 23e) (Type, Print)

and

Mance

O.

DHMH 16 Ray 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day March 13, **Physician** 1997 Anna M. Doughty 5:30 PM /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 3662 Dudley Avenue Baltimore N/A 8. Date of Birth (Month, Day, Year)
June 14, 1 5. Social Security Number If Under 1 Year If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Fulleral Days 1□M 2□F Director 218-12-4259 76 Yrs Maryland Usuai Residenca of Decedent 10a State 10b. County 10c. City, Town or Location rai', or items 23a or 28a-f ahow Examiner must be notified at 10d. Inside City Limits Director 1 Ves 2 □ No Maruland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3662 Dudley Avenue 21213 U.S.A. Pegas 1 end 2 should be filed within 72 hours after daath nent of Heelth and Mental Hygiena.
Instit if lean 72 is marked other than "naturat, or items 23.
Iny or other traumatic event, the Media Exertine mustry or other traumatic event, the Media Exertine mustry or other traumatic event, the Media Exertine mustry or other traumatic event, the Media Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ᡚ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: White. þ Specify: 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Dacedent's Education (Specify only highest grade completed) 16a. Decadent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotiege (1-4or 5+) 12th grade Homemaker Own Home Baltimore, Maryland 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Walker Bettie Kress 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Gary R. Doughty (Son) 3202 Berkshire Road, Baltimore, Maryland 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 XBurlel 2 ☐ Cremation 3 ☐ Removat from State permit. Pega Department of important: if any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Baltimore National Cem. 3-17 Baltimore, Maryland 21. Signature of Funeral Service Licenters 22. Name and Address of Fecility
Schumuner Funeral Home 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complication. If at caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final Chronic Obstructive Pulmonery disease or condition resulting in death) **Examiner** The law requires that the death certificete be axecuted buriel-transit Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Diseasa or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical tha Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown Be Completed by 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy parformed? ficate has Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) P 1 ☐ Yes 212 No to Certification: 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Piace of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after Dire 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Complately filled Hospital 24 hours a Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. Medicai 29a, Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (itam 23a) (Type, Print)

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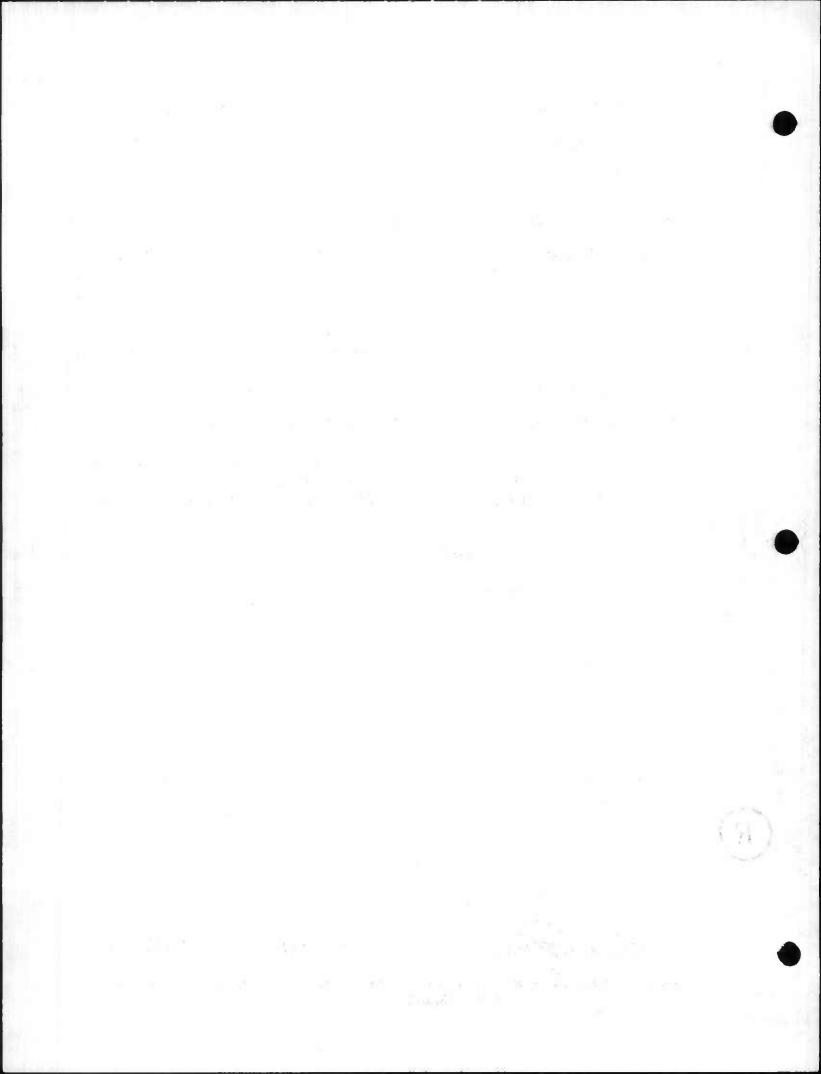
RAVEN BLUD

BALTO. MD

State Registrar

1.32 Megisyar's Signay Land 31. Date filed (Month, Day, Year)
MAR 1 9 1997

SPERLING, M.D.



State of Maryland / Department of Health and Mental Hygiene

Physician /Medical		Decedent's Name (First, Middle,					2. Date of Dee		3. Time o	f Death
		Margaret	Did	ier			March	17 1	997 10:	20pi
Examiner	4 14	Fecility Name (If not institution,				4b. City, Town, or L		4c. County		
	5	Corsica Hill Social Security Number				Centerv ar If Under 24 Hrs.	-		en Anne	
Funeral Director	2	13-16-4249 suel Residence of Decadent	1□ M 2 X F	7. Age (In yrs. lest bir 92	Adverted Day		8. Date of Birth (Month, De) May 1	7,1904	9. Birthplece (State of Country) Maryla	n d
Word Word		ea. State 10b. County		10c. City, Tow	n or Location				10d. Inside C	ity Limits
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or 28a-f s be norther Director	10	e. Street and Number			10f. Zip Code	9		log. Citizen of V		
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27 is a r trau	1000	r. Kenneth B. D			1027 Long			nville,		1638
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SESS		I male T. Z			Leonard	J. Ruck,			MJ 01014	
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State of Maryland / Department of Health and Mental Hygiene

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Physician	
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Examiner	

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permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Pygiene. Important: If item 27 is marked other than "netural", or items 23s or 28s-f show any Injury or other traumstic event, me Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

or Attending Physician: The law requires that the death certificate be executed To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit vivision of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death EVELYN IRENE EAST 12, 1997 3:00 P.M. MARCH 4b. City, Town, or Location of Death 4e. Facility Neme (If not institution, give street and number) 4c. County of Death 114 COUNTRY CLUB DRIVE GLEN BURNIE ANNE ARUNDEL | If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | APRIL 12,1909 Birthplace (State or Foreign Country) MARYLAND 5. Social Security Number 7. Age (In yrs. lest birthdey) 1 □ M 2 ▼ F 215-03-1260 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 ☐ No ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 114 COUNTRY CLUB DRIVE 21060 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Merried 1 Yes 2√ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorcad 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12TH GRADE SECRETARY TRANSPORTATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) MAURICE E. GRIMES SARAH VIRGINIA COLEMAN 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) CHARLES R.B. WYATT, SR. 3640 GREENVALE ROAD - BALTIMORE, MD 21229 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LOUDON PARK CEMETERY 3/15/97 BALTIMORE 21. Signature of Funeral Service Lipensee 22. Name and Address of Facility HUBBARD FUNERAL HOME INC. Tllag Coleman 4107 WILKENS AVENUE-BALTIMORE, MD 21229 23e. Part1. Of ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finel disease or condition resulting in deeth) Acute impocordial inforction snon Arten discose Due to (gras a consequence) of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting In deeth) Last Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

MD

Director

þ

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f eho traumstic event, the Medical Examinar must be nothing as

permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mentel Hygiena. Introcrant: If tem 27 is marked other than "natural", or the any injury or other traumatic event, the Medical Examinations.

Baltimore, Maryland 21215-0020

deeth with the Maryland

Examiner Physician/Medical þ Completed

Be

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Certification:

Medicai

29e. Certifier

physician and s the buriel-transit Records, P.O. Box 68760 The law requires that the death certificete be ed by the attending detached for use as ate has

To the Hospital or A within 24 hours after To the Funerel Direc completely filled in the

1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 1 Neturel 5 Pending investigation 2 Accident 3 Sulcide 6 Could not be determined 4 Homicide

Place of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28b. Time of

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie

31. Date filed (Month, Dey, Year)

MAR 1 9 1997

29c. License number

29d. Dete signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

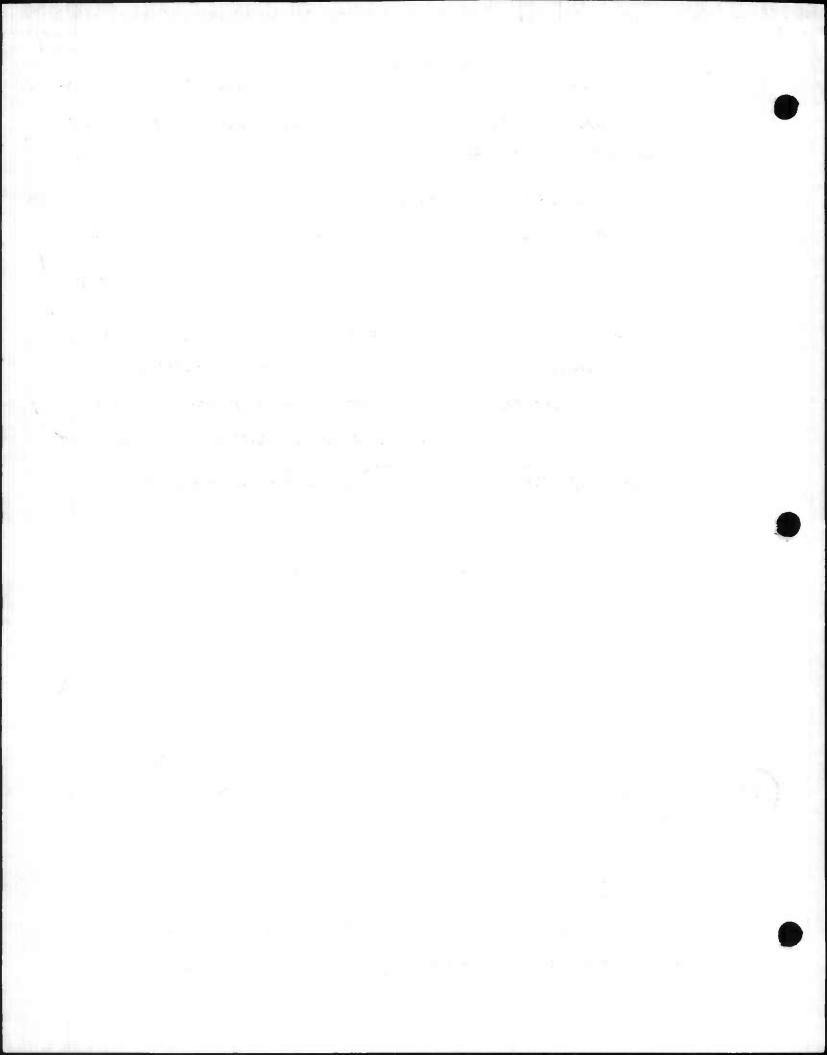
36384

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

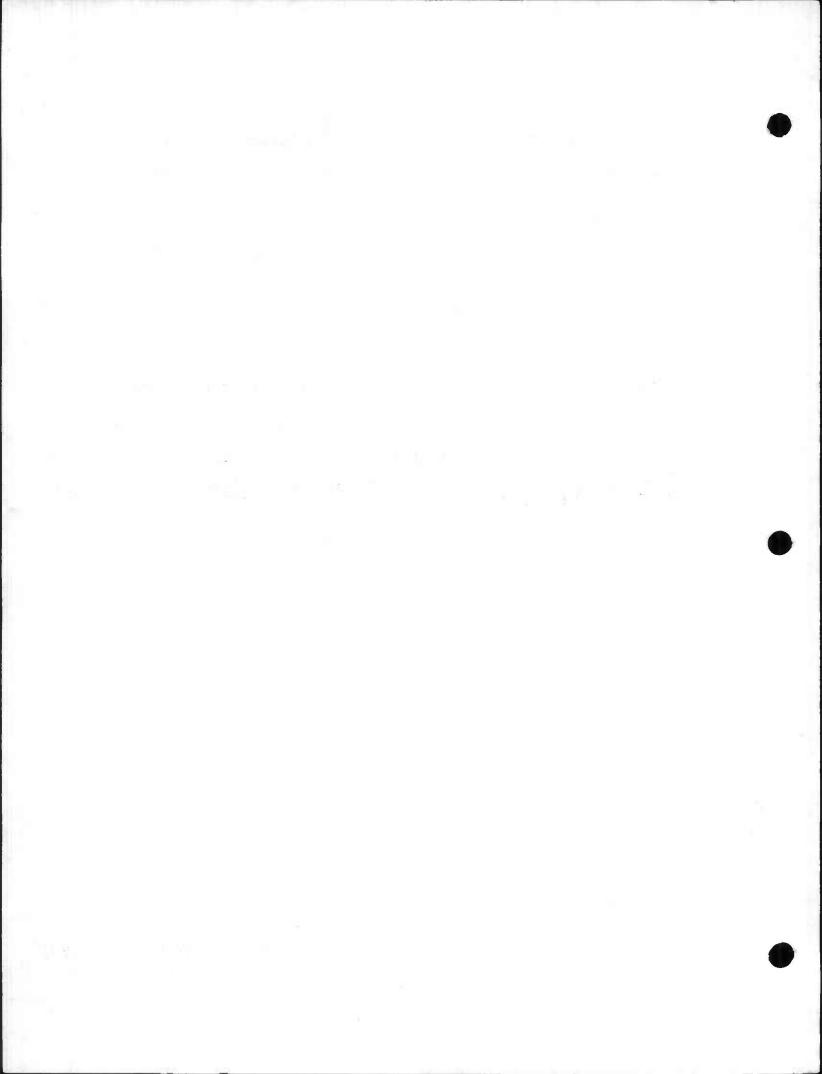
DR. BASSIM BADRO - 7845 OAKWOOD ROAD-SUITE 106-GLEN BURNIE, MD. 21061

Registrar

32 Registrar's Signature



						epartment of I Certificate of			Reg. No.	97	08428	
	/sicia ledic		GEORGE FELLA				2. Date of Death South Month Day Year MARCH 17 1997 12:52 P.					
	amino eral	er	4a. Facility Nama (If not institution, give Stella Maris 5. Social Security Number 6. So 126-26-7423 Usuel Restdance of Dacedent	yrs. last birtho	day) If Under 1 Year	Hours Min. (Month,		N/A Birth Day, Year) 9. Birth Co		thplece (State or Foreign ountry)		
ryland	9		10a. Stata 10b. County 10c, City, Town or Location							1	0d. Inside City Limits	
th the Ma or 28e-1 s	O DICTURED	Director	10e. Street and Number			rbutus 10f. Zip Coda			1 ☐ Yas 2 ☐ No			
eth wi	O TRIE		5515 Selma Avenue			21227			United			
laryland 21215-0020 2 should be filled within 72 hours effer deeth with the Manyland and Mental hygiene.	Examiner	by Funeral	11. Merital Stetus 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ♣ No If Yas, Giva Yeer or Detas:	If Yas, specify Cuban, Mexican, Pua			Specify Yas or No- rio Rican, atc.) 14. Rece - American I Bleck, Whita, etc. Specify: whit			etc.	
21215-0020 d within 72 hours of giene. or then "neturel", or	or outer traumate avent, or moster.	Completed	15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) College (1-4or 5+)			16a. Decedent's Usuel Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) barber 16b. Kind of Buelness/li self-emp1						
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Vlar uld be Wenta	100 80	ToB	John Fellas			Evridiki Komodromou						
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Baltimore, permit. Peges 1 ar Department of Hear importent: if Itam?	once.		Meadowridge Memorial 3/20 Dorsey, Maryland 21 Donation S Dothar (Specify) Meadowridge Memorial 3/20 Dorsey, Maryland 22. Name end Address of Fecility Ambrose Funeral Home, Inc. Arbutus 1328 Sulphur Spring Road 21227								outus	
Physic /Medi Exami	cal ner	23a. Pert 1. Enter the disease, or combilications that caused the deeth. Do not anter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each fina. Immediate Causa (Final disease or condition resulting in death) Due to (or es e consequence of):								Approximete Interval Between Onset and Death 3 month		
The cords, P.O. Box 68760, The law requires that the death certificate be associted the has been signed by the ettending physician end	DO DE L	D	Sequentialty list conditions, if any, laading to immediate cause. Enter Undartying Cause (Disaasa or injury that initiated events rasulting in daath) Last b. Dua to (or as a consequence of): C. Dua to (or as a consequence of): d.									
hat the death cert ad by the ettendin	5	P -	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F						23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown			
Ital Records, Penn: The law requires that	3 .	Completed by							an autopsy ormed?	ave cor	ara autopsy findings attabla prior to mpiation of causa death?	
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R	3	- -	1 ☐ Yas 2 ☐ No 27. Menmar of Death 1 ☐ Vatural 5 ☐ Pending 2 ☑ Accidant Invastigetion	1 ☐ Inpatiant 28a. Data of Injury (Month, Dey Yea	na of 28c. Inju	4 Li Huishiy	loma 5 □ Rasidance 6 □ Other (Specify) HOSPIC 28d. Dascribe how Injury occurred) HOSPICE		
DIVISI DOURS after dea American Director	the day in the	Certification:	3 ☐ Suicida 6 ☐ Could not be datarmined	28a. Ptaca of Injury - At homa, farm, straat, fee building, etc. (Specify)		, straat, fectory, offica	ctory, offica		28f. Location (Streat and Number or Rural Routa City or Town, Steta)		f Routa Number,	
2263	Carin	edical	29a. Cartifier (Check only one) Certifying Physician: To the bast of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and mannar as stated. Control of the bast of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and mannar as stated. Control of the bast of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and mannar as stated.								ated. the cause(s)	
To the To the			29b. Signeture end titta of cartifiar				29c. License number D40480			29d. Data signed (Month, Day, Year) March 17 1997		
	P		30. Name and addrass of person who complated causa of daath (Itam 23a) (Type, Print) Fernance V. Fether MD SALT MD 21206							1		
Reg	State Jistra	_	31. Dete filed (Month, Qay, Yaer) MAR 1 9 1997	32. Registrar's S	ignatura A-Rond	<u> </u>						



State of Maryland / Department of Health and Mental Hygiene

08429 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Death Month **Physician** Frederick Gillis 7:00 pm 2 1997 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MEDICAL CENTER 7. Aga (In yrs. last birthday) If Undar 1 Yaer If Undar 24 Hrs. 8. Deta of Birth (Month, Pay, Year) May 1, 1948 Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex **Funeral** 11XM 2□ F Months Deys Hours Yrs. Director 48 unknown Maryland Usual Rasidance of Decedant the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exampler must be notified at Maryland 1⊠ Yes 2□No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 1058 Argyle Avenue 21201 U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, White, atc. 1 ☐ Yas 2 ☒ No 1 Naver Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: Black P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) Print shop permit. Pages 1 and 2 should be filled wit Department of Health and Mental Hygienr Important: If Item 27 is marked other that any Injury or other traumatic auton Printing Clerk 17. Fathar's Name (First, Middle, Last) 18. Mothar's Nema (First, Middle, Maiden Sumame) Be Fred Gillis Geneva Thomas 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Gillis - brother 1808 Bolton Street, Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 21. Signatura of Funerel Sarvice Licensee 22. Nama and Addrass of Facility State Anatomy Board, 655 W. Baltimore Street B. Wan Sant Joseph Baltimore, Maryland 21201

23a. Parfl. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, Maryland 21201 Approximate interval Between Onsat and Death Physician /Medical Immediata Causa (Final SEIZURES diseasa or condition resulting in death) Examiner Due to (or as a consequence of): INFARCTION MYOCARDIAC burial-transit certificate be executed Sequantially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disaase or Injury that Initiated events rasulting In death) Last Dua to (or as e consequence of): and P.O. Box 68760, PLTY PERTENSION

Dua to (or as a consequence of): NON COMPLIANT Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown SUBSTANCE ABUST Records, þ 8 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Wes an autopsy performed? page 2 1 Yas 2□No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Was case rafarred to medical 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 2 28c. Injury et Work? 27. Manner of Death 28a. Deta of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: after deeth. Injury 7 PM 5 Pending investigation Netural NATURAL 3/2/97 1 ☐ Yas 2 No 2 Accidant 6 Could not be 3 Suicida 28a. Placa of Injury - At homa, ferm, straat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicida BATTHORE HD 1058 ARGYLE 12 Cartifying Physician: To the best of my knowledga, death occurred at tha time, data and place, and due to the cause(s) and mannar as steted.
2 Medical Examinar: On the best of axamination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) end mennar stated. Medical 29e. Cartifier (Check only 29b. Signatura and titla of pertifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) 7003472 NE 9425 EUTAW PC, BALTINGRE MD 30. Name and address of person who complated causa of death (Itam 23a) (Typa, Print) PETER Cru ANG Like Danies - House 31. Data filad (Month, Day, Year) State 9 1997 Registrar

DHMH 16 Rev 6/95

Items5,9,12,13,16a,16b,17,18,20b,20c 4-28-97 FilmG746 W.H.Per F/H 97-1208-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. **CMK** State of Maryland / Department of Health and Mental Hygiene 08430 UNK. #97-059 Items: 23 part I,27,28a-f per MEO G-746 4/10/97 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death MARCH 08, **Physician** 1997 CHARLES GILMORE 0306AM /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death . County f - th Examiner 1341 WEST NORTH AVENUE BALTIMORE CITY 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer | If Under 24 Hrs. Birthplece (State or Foreign Country)
 NC 8. Date of Birth (Month, Dev. Year) **Funeral** 1√2 M 2□ F Months Days Hours 46 Yrs. Director August 8,1950 unknown unknown Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show must be notified at Director Maryland Baltimore 1 X Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ò U.S.A items 23a 1341 West North Avenue 21217 unknown Funeral 12. Wes Decedent Ever in U.S.
Armed Forces? Unknown
1 | Yes _ 2 k| No
If Yes, Give/
Year or Dates: 11. Marital Status unknown Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian a filed within 72 hours after de Il Hygiene.
other than "natural", or item Bleck, White, etc. the Medical Examiner 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Baltimore, Maryland 21215-0020 Specify: Specify: Black by 3 Widowed 4 Divorced unknown Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16h, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Construction Co. Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker unknown unknown unknown Pages 1 and 2 should be filed value of Health and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Essie Nora Williams Alton Gilmore unknown -unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
124 W. Franklin Street Baltimore, MD. 21201 19a. informent's Neme/Relationship (Type, Print) Department of Health er Important: If itsm 27 is any injury or other trau unknown John Gilmore (Brother) 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burlal 2 □ Cremetion 3 □ Removal from Stete Landsdowne, MD. Zion Cemetery 4 □ Donetion 5 【XOther (Specify) in-state 21. Signature of Funeral Service Licansee
Joseph B. Van 22. Name end Address of Facility
State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201 Paul. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical immediate Cause (Final HYPOTHERMIA COMPLICATING DRUG ABUSE disease or condition resulting in death) Due to (or as a consequence of) Examiner physician end the burial-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) 88 **BSI** P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was en eutopsy Yes 2 No Division of Vital or Attending Physician: efter death. Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 WOther (Specify) AT SCENE 10 1 XYes 2 No uneral 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) Certification: founding 3:00 1 Natural To the Hospital or Attendir within 24 hours efter death. To the Funeral Director: At completaly filled in by the fu 1 Yes 2XX No Accident Investigetion found 3/8/97 Subject exposed to cold environment 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1341 W. North Ave. 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 - Homicide Street Baltimore, Md. 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier unce O.C.M.E. MARCH 08, 1997 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Koneu Ry DNOD D 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State whie Dividson Pandale

Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 305 Kevin M . GREEN MARCH 4a. Fecility Neme (If not institution, give street end number) BAYVIEW HOSPITAL 4b. City, Town, or Location of Deeth BALTIMORE 4c. County of Death n/a 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Deys Hours Min. MAR 1997, Year 9 6 1 5. Social Security Number 6. Sex 220 - - 90 - - 11671011 2 F 9. Birthplace (State or Foreign BALLIN MORE, MD Usual Residence of Decedent 10s State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE 1 Yes 2 No MD n/a 10f. Zlp Code 21218 10e. Streat end Number 2709 THE 10g. Cifizen of What Country? ALAMEDA UNITED STATES 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ☐ VN If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Biack, White, etc. 11. Meritel Stetus 1 Never Merried 2 Merried 1 ☐ Yes Y No Specify: BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) LABORER various trades 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumame) DAVIS GREEN OUILLE WILLIAM 19a. Informant's Neme/Reletionship (Type, Print) MARION GREEN 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 711 N. PAYSON ST., BALTIMORE, MD 17 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 □ Buriel 2 □ Cremetion 3 □ Removel from Stete MILLS, 3-8-OWINGS GARRISON FOREST VA CEM. 4 ☐ Donetion 5 ☐ Other (Specify) MD 21. Signature of Fugeral Service Licensee 22. Neme end Address of Fecility AVENUE Ε. NORTH WM. C. MARCH FH.-1101 23a. Pert1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth Immediate Cause (Finel · Retroviral Syndrome diseese or condition resulting in deeth) regressive Multifocal Lenkuescepholopathy Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy 1 Syes 2 □ No 1 ☐ Yes 2 ☑ No 25. Wes case referred to medicel examiner? 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury et Work? 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 5 Pending investigetion Noturel Naturel

Physician /Medical Examiner

Department of Important: If any injury or once.

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Funeral Director

filed within 72 hours after death with the Maryland Hyglene. ther then "naturet", or flems 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after death with the Marylanen of Health and Mental Hyglene.
Int. II ham 37 is marked other than "natural", or items 23a or 28a-f show my or other traumatic event, the Medical Examinal must be notified as

Baltimore, Maryland 21215-0020

physician and s the burial-transit he law requires that the death certificate be asscuted signed by the a page 2 s

Physician/Medical

by

Be

2

Certification:

Medical

2 Accident 3 Sulcide

4 Homleide

Records, P.O. Box 68760,

To the Hospital or Attandi within 24 hours aftar death To the Funeral Director: A complately lilled in by tha fi

34

State Registrar

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) end menner stated. 29e. Certifier (Check only 29b. Signeture end title of certifier 29c. License number 29d. Dete eigned (Month, Dey, Year) MP

1 Yes 2 No

30. Name end address of person who completed cause of death (item 23a) (Type, Print) Chloe

6 Could not be determined

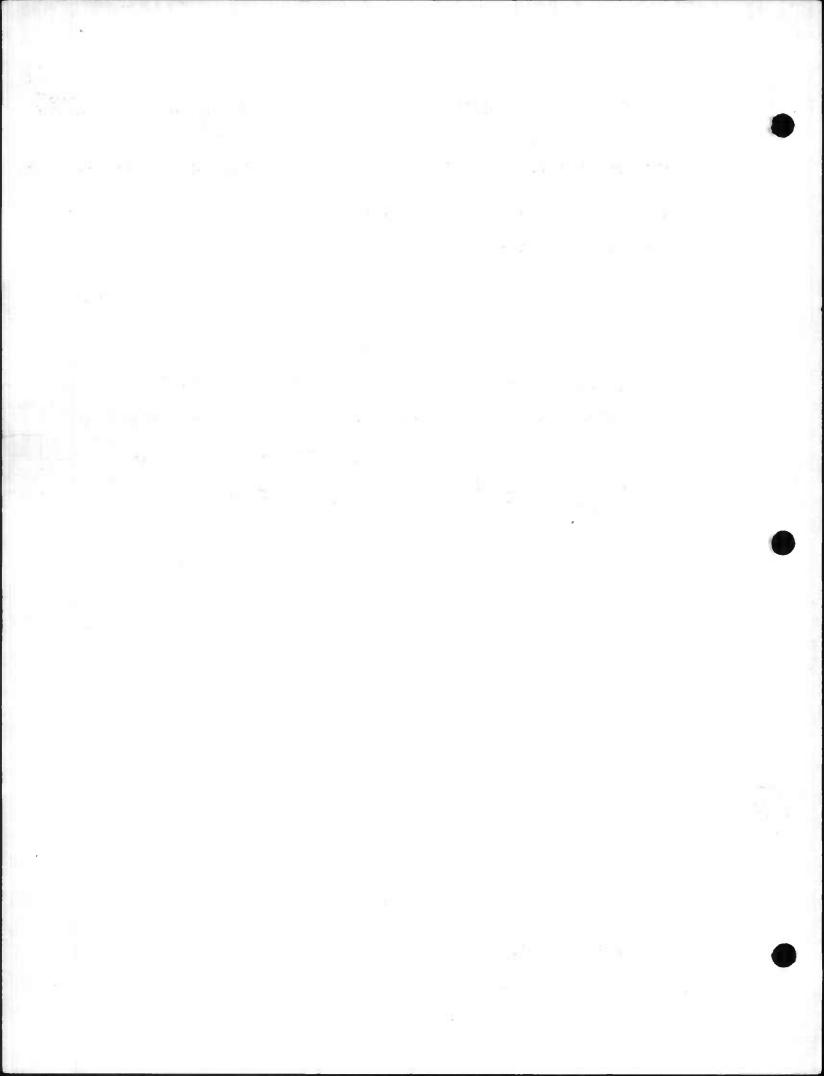
720

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

RUSS 1159 38, Registrar's Signal Rufferd Avenue

Baltimene, MO 21205

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Items: 7,8 per F.H.G-745

3/State of Maryland / Department of Health and Mental Hygiene
Item & Per FH Film G745 3-18-97 rja

Certificate of Death Certificate of Death 1. Dacedent's Name (First, Middle, Last) 2. Date of Deeth March **Physician** 0150 am GLOVER JOHNAY JR. 13 /Medical 4a. Facility Name (II not Institution, give street and number) 4b. City, Town, or Location of Deeth **Examiner** 4c. County of Death BALTIMORE CHURCH HOME HOSPITAL 7. Age (In yrs. last birthday) if Under 1 Yeer If Under 24 Hrs.

63 G4 Yrs. Months Deys Hours Min.

A PR. 4, 1932 5. Social Security Number 2 4 7 - 5 2 - 4 1 6 2 9. Birthplace (State or Foreign Sountry) CAROLINA **Funeral** 1 X 1 2 F Director Usual Residence of Decedent 10e. Stete 10b. County r than "natural", or itams 23s or 28s-f show the Medical Examinat must be notified at 10c. City, Town or Location 10d. Inside City Limits n/a BALTIMORE MD Y Yes 2 No Director 10e. Street and Number 10f. Zip Code filed within 72 hours efter death with 21213 1515 BROADWAY Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11 Maritai Status 1 Never Married 2 Married 21215-0020 1 ☐ Yes A ☐NO Specify: Be Completed by Specify: BLACK 3XVidowad 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) LONG-SHOREMAN) LABORER (STEAMSHIP TRADE i. Pages 1 and 2 should be filed w tment of Health and Mantal Hygien tant: If item 27 is marked other ti jury or other traumatic event, in marked other Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JOHNNY MINNIE W ASHINGTON GLOVER 0 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1515 N. BROADWAY, BALTIMORE, MD 21213 GLOVER JERIMIAH 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) permit. Page Department of Important: If any Injury or once. SOUTH SANTEE CEM. ship out McCLELLANVILLE, SC 21. Signature of Fugura Carvice Licenses 22. Name end Address of Facility AVENUE FH. -1101 E. NORTH WM. C. MARCH nes ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata Interval Between Onset and Death Physician PHEUMONIA De days /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, the Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? signed by t 1 Yas 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings evailable prior to completion of cause of death? Completed DIABETES TYPE I 24a. Was en autopsy performed? certificate hes 1 Yas 2 No 1 ☐ Yes 2 ☐ No Attending Physician: Be 25. Was casa referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Division 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital or within 24 hours aff To the Funeral Di completely filled in 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signeture end title of certifier 29d. Dete signed (Month, Day, Year) 29c. License number specialist 30. Name and addrass of person who complated causa whith (Itam 23a) (Type, Print) 100 M. BROADWAY BACTIMORE, YEARY LAND 21231 NENEUSA MAVARRO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Alia Davidson

DHMH 16 Ray 6/95

Registrar

UNK. 97-057 97-1205-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

wlc Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Deeth 3. Tima of Death **Physician** Vear GRAY March 7, 1997
ocation of Death 4c. County of Deeth KEVIN /Medical 7:00p4a. Fecility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE 1900 E. LANVALE STREET If Undar 1 Yaar if Undar 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) 2 - 27 - 6 5. Sociel Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1**Ø**M 2□ F Months 30 21886 400 Usual Rasidance of Dacedant 4007 Vrs Director Md 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Med N.A. Bulto Director Yas 2 No 28a-f 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 6 must be 4.5.4 1507 21213 238 Funeral 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 220 No If Yas, Giva Yeer or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Ricen, etc.) 11. Maritel Status 14. Raca - Amarican Indian, Black, White, etc. 1 Navar Married 2 Married Specify: Black 1 ☐ Yas 2 No þ 3 ☐ Widowed 4 ☐ Divorced Completed Baltimore, Maryland 21218-0 16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry ELectronic. Elamantary/Secondary (0-12) Collega (1-4or 5+) Laberer permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumarite event 17. Fethar's Nema (First, Middla, Last) 18. Mother's Nama (First, Middle, Maidan Surnarga) Williams KOGET Gwendolyn 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Informant's Name/Retetionship (Type, Print) YOLANDA 3613 Balto. md. 21218 Rd. 20b. Placa of Disposition (Nama of cematery, cramatory or other place) 20e. Mathod of Disposition Deta 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Remove from Stata LANDSHOWNE · Md 3/22/97 210N CEM 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Locks Juneral Home 1364 n. Central Locks 23a. Part / Entar the disaese, or complications that caused the deeth. Do not antar the mode of dying, such as cerdiac or respiretory errest, shock, or heer feilura. List only one cause on each line. Approximata Intarvai Between Onsat end Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in death) Multiple Gunshot Wounds Examiner Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medicai the Due to (or as a consequence of): for use es P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by ti 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Wera sutopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy performed? peen 1R Yes 2 No 1. Yas 2□ No certificate Division of Vital 25. Was cese rafarred to medicel axaminer? Be 26. Place of Daath (Check only ona) Hospital: 1 Xes 2 No Other: $_{4\square}$ Nursing Homa $_{5\square}$ Rasidance $_{6}$ Wher (Specify) SCENE2 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28e. Deta of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28b. Time of 28c. tnjury at Work? 1 Naturei 5 Pending 1 Yas 2. No invastigation 2 Accident -7-97 1849M Subject was shot 28t. Location (Street and Number or Aural Acute Number, City or Town, State) 1900 Block East Lanvale 3 ☐ Suicida 6 Could not be 28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 4 R Homicide

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely lilled in by the funeral director; p

(Check only one) 29b. Signeture end titla of certifiar

29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 8, 1997

30. Nama and addrass of person who completed causa of daath (ttem 23e) (Type, Print)

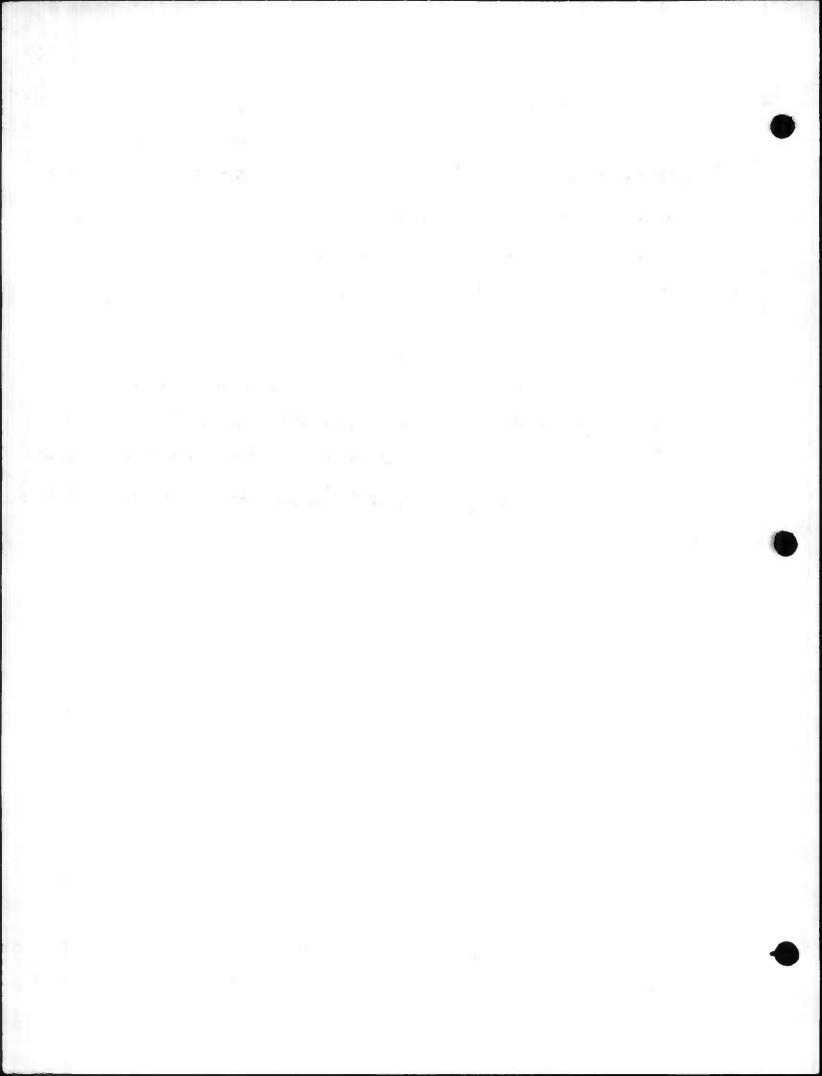
111 Penn Street, Baltimore, Maryland 21201 Stephen S. Radentz MO 31. Data filed (Month, Day, Year)
MAR 1 9 1997

State Registrar

Medicai

29a. Cartifian

32. Registrar's Signatura with Davidson-Randelle

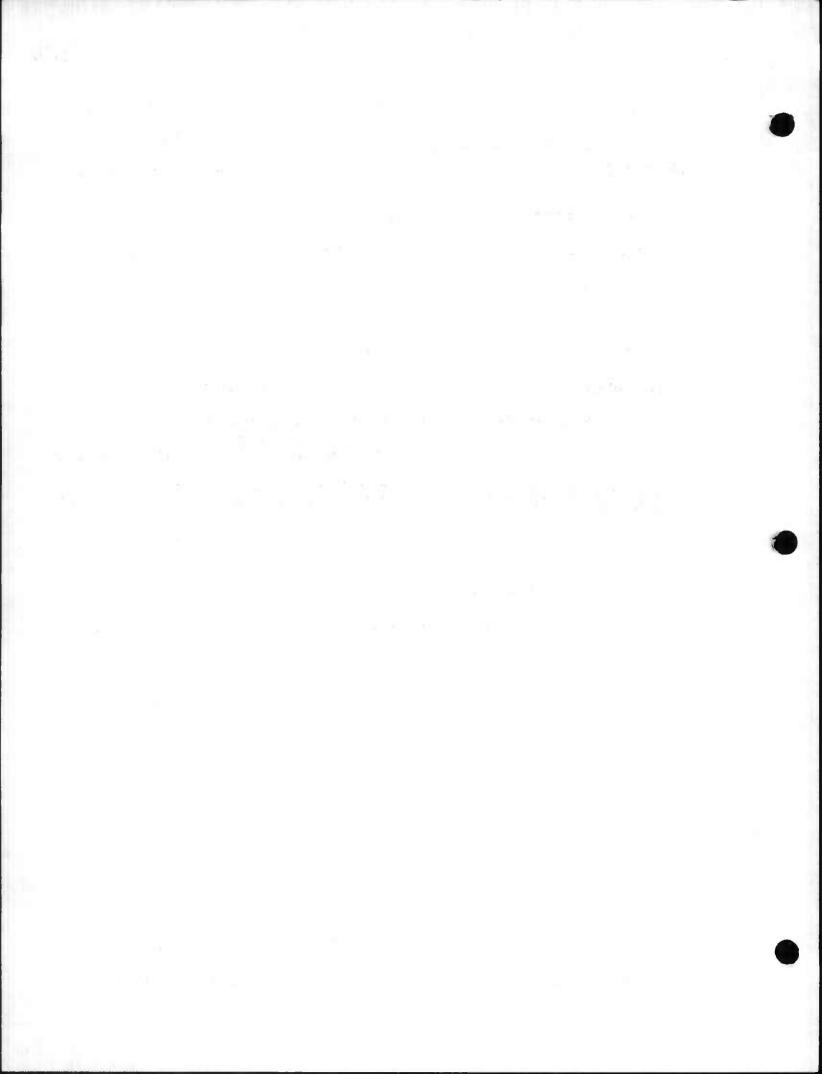


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State of Maryland / Department of Health and Mental Hygiene 97 08 4 34

						(Certifica	ate of	Death		Reg. No.		004	0 1
ï	Dharaia		1. Decedant's Nama (First, Midd.	lia, Last)							Data of Death Month Day Yaar			of Death
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ĵ,	Exami		4a. Facility Nama (If not institution	on, giva street and numbe	r)				4b. City, Town, or		h 4c. Count	ty of Death		
			Franklin Squar	e Hospital	Cente	r			Rosedal	2	Balti	more		
ı	Funeral Director		5. Social Security Number 218–26–2672	6. Sax 7. A 1 M 2 X F	65	last birtho	Month	dar 1 Yaar ns Days			th Year) 25,1931	Cou	placa (State ntry) yland	a or Foraign
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	the N	Director	10e. Street and Number					Zip Coda			10a Citizen of	What Cou		
	ath with	rai Di	960 Kinwat Ave					212			10g. Citizan of What Country? U.S.A.			
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Ma			19a. Informant's Name/Relations Edmund R. Grzec		\				t and Numbar or R				o Coda)	
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Baltimore, Maryland 21215-0020	pemit. Peges Department of I important: If ite any injury or of		1 ∰Burial 2 ☐ Cramation 4 ☐ Donation 5 ☐ Other (S	Specify)	Sac	red H	cramatory o	of Jes	ca) 3/20/19 Sus Cemet	ery	Baltin			Md.
Bal	Departimon impor any in		21. Signature of Funaral Sarvice	Licansea Cura Bo			Bruzo	dzins	ki Funera Eastern			БМ	21221	
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	/		Ham lt	m Ima	H			RD02	125		3/61	97		
	6		30. Nema and address of person	who completed cause of	death (Item	23a) (Tu	rpe, Print)					1 1		
	7		Hamilton Small					Driv	e Baltim	ore, Mar	yland 2	1237		
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Registrar



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						Certificate of			Reg. No.	7 08435		
п	Physic	ian	Decedent's Name (First, Middle, Last					2. Date of De Month	Day Y	3. Time of Death		
5	/Medi	As English Alama and a state of the state of						MAR	11 199			
2	Exami	ner	2807 BARTOL AVE.	street end number)		_	4b. City, Town, or L BALTIM					
-	Funeral		5. Sociel Security Number 6. Se	x 7. Ac	e (In yrs. last birth	idey) If Under 1 Year			N/A			
L	Director		578-54-8201 X ^{1E} Usuel Residence of Decedent	ZM 2□ F		rs. Months Deys	Hours Min.	8. Date of Bird (Month, De AUG. 12	y, Year) ,1901	Birthplace (Stete or Foreign Country) GERMANY		
	the Maryland 28a-f show noulfied at	tor	10a. State 10b. County MD N/A		10c. City, Town	or Location LTIMORE				10d. Inside City Limits Y☐ Yes 2☐ No		
	or 284	irec	10e. Street and Number		1	10f. Zip Code			10g. Citizen of Wha	at Country?		
	th will	alD	2807 BARTOL AVE.			2	1209		USA			
020	after dea or items	by Funeral Director	11. Maritel Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cut	Hispenic Origin? (Sp san, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	14. Raca - Bleck, Specify:	American Indian, White, etc. WHITE		
21215-0020	within 72 hours ana. then "natural",	Completed	15. Decedent's Edu (Specify only highest gred Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or ! 5+	16a. [(5+)	Decedant's Usuel Occu Give kind of work done life. DO NOT use retire ATTORNEY	pation during most of work ed)	ring	16b. Kind of Busin			
		Be Co	17. Fathar's Nama (First, Middle, Last)	31		ATTOMBE	18. Mothar's Nam	e (First, Middla,	Maidan Sumame)	Avv		
ylar	S should be filed with end Mentel Hygiana. Is marked other than aumatic event, the M	To B	DR. CONRAD	GOULD)		REGIN	A	PPER			
, Maryland			19a. Informant's Name/Ralationship (T) BETTY GOULD (WIF	ar, City or Town, St MD 212								
Baltimore,	of H		20a. Mathod of Disposition 1 XBurlel 2 □ Cremation 3 □F 4 □ Donation 5 □ Other (Specify)	lemovel from State	20b. Pleca of I cemetery HAR S	Disposition (Name of cremetory or other ple		Date 3/97	20c. Location - Cit			
a E	구두루루		21. Signetum of Fundral Service Los	2	HAR D	22 Name and Addr SOL LEVI				ORE, MD		
m	Deperminant in point		1 mm	X-	•					, MD 21208		
			Part1. Enter the disease, or adhpt shock, or heart lature.	nons that caused a cause on each li	the death. Do no					Approximete tntarval Batween Onset and Deeth		
	Physician /Medicai Examiner		Immediata Cause (Final disease or condition rasulting in death)	Cond	estin	e Heart ensequance of): enosis	+ Fail	ue		3 months 2 years		
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o o	ficete be executed g physician end as the buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter list deriving									
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	death e atte	sicia	Part II. Other significant conditions con	tributing to death b	ut not resulting in t	ha underlying cause of	van in Part I	23b. Did t	obacco use contri	bute to the cause of death?		
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of Vital Records,	sign d be	Completed by						24a. Wes	an eutopsy amed?	24b. Were autopsy findings available prior to completion of cause of daeth?		
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Division	5 £ 5 €	Certification:	3 Suicide 6 Could not be datermined	28e. Plece of Injubuilding, etc.		n, street, factory, office		28f. Location (S City or Tow		or Rural Route Number,		
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	8	-	30. Name and addrass of person who co Robert B Shoche	mpleted causa of d	aath (Itam 23a) (T	ype, Print)	10 ALD	5,1072	Bretten	10re MD 21215		
	Sta		31. Date filed (Month, Day, Year)	22. Registra	ar Signature	PRIVERON	- rive.	wiell	· (action	10 PC 1001 2021)		
	Registr		MAR 1 9 1997	. a Davidson		4						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08436 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death GREENFELD MAR U SADIE 14-10 Hos 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HUSPITAL CENTER RANDALLSTOWN NORTHWEST BALTIMORE 7. Age (In yrs. lest birthdey) If Under 1 Yeer If Under 24 Hrs.

North Days Hours Min. 5. Sociel Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 1 ☐ M 2 💢 F 82 212-50-2781 JAN.14,1915 MARYLAND Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6604 SHELRICK PLACE 21209 USA 11. Marital Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: WHITE 3 ₩idowed 4 Divorced Yeer or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 BOOKKEEPER DOOR & HARDWARE 17. Father'a Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) **ISADORE** BLUMBERG RACHAEL DAVIS 19a. Informent's Name/Relationship (Type, Print)
ESTATE OF SADIE GREENFELD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C/O JOHN G. WHARTON (ATTY) 1111

20a. Method of Disposition (Name of cemetery, crematory or other place) 111 S CALVERT ST., SUITE 1400 BALTO., MD 21202 20c. Location - City or Town, State 4 □ Donation 5 □ Other (Specify) BALTIMORE HEBREW 3/14/97 REISTERSTOWN, MD 21. Signeture of Funeral Service Licansee 22. Name and Address of Facility
SOL LEVINSON & BROS., INC. Februson 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, euch es cardlec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth CONGESTIVE CARDIOMYOPATHY Due to (or es e consequence of)

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

Directo

Funeral

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MD

Funeral

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hours effer deeth v Department of Haelih end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a anal injury or other traumatic evant, the Medical Examiner must lonce.

Baitimore, Maryland 21215-0020

with the Maryland

physician and the burial-transit thet the death certificate be axecuted

P.O. Box 68760. ed by the detached ed by 1 Hospital or Attending Physicien: 24 hours after deeth. Funerel Director: After this certifio To the Vithin 2

Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? ORTIC STENOSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed 1 Yes 2 H 1 ☐ Yes → No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yea 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 120npatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28c. Injury at Work? 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 1 DNatural 5 Pending Investigation 1 Yes 2 No 2 Accident 8 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homloide 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) 77337 MARCH 11, 1997

State Registrar

Please Type or Print in Black Indeible Ink. Assure All Coples Are Legible.

				State of M	arylan	-	artment <i>rtificate</i>			and M		giene Reg. No.	97	084	37
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			Howard County Ge	neral Hosp	ital				Colu	mbia		Howard			
	Funeral	Г	5. Sociel Security Number 6.	Sax 7. Ag	e (In yrs. l	last birthday)	If Undar 1 Months	Yaar Days	ys Hours Min. (Month, Dey, Year) 9. Birthplet (Month, Dey, Year) Country				ca (Steta d	r Foreign	
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	farytan show	5	I Silverior			1000					10d. Inside City				
	the A	Director	MD Howard 10e. Street end Number			lumbi	a 10f. Zip C	Codo			1	10a Chinan a	4 Milhat Count	2.5	
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5	of Attender dea Director	ert	4 Homicide	building, et			,,				City or Tov	vn, Stete)			
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	Physici /Medi		Rhea Christine H						March		L997	2:50 PM	
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	Funeral Director	7	216-20-3207	Sax 7. Age	a (In yrs. las: 86	Yrs.	Months Days						
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Baltimore, Maryland 21215-0020	n 72 hours after death with the Maryland "naturel", or items 23s or 28s-f show edical Examinet, must be notified at	þ	1 Nevar Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yas, Giva Year or Datas:	No		Yes, specify Cub		to Micen, etc.)		ek, Whita, Whi		
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Ma	alth and 27 is me		Margaret Poe/ ni				tags Hea		owson, N			(2009)	
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alt:	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the MODGS.		21. Signeture of Funarel Service Lice	**	- puran	22.	Nama and Addre	n Garden	5/19/9/ tchell-W	liedefeld	d Hor	iryiand me. Inc.	
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			Decedent's Name (First, Middle,		naryianu		cate of	Death		eg. No.	7 08439	
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	/land		Usual Residence of Decedent 10a. Stata 10b. County		10c. City, T	own or Location	1				10d. Inside City Limits	
	a-f sh	ctor	Maryland Baltim	ore County	Luth	erville					1 ☐ Yes 2 ☑ No	
	or 28	Director	10e. Street end Number			10	f. Zip Code		1	0g. Citizen of Wh	nat Country?	
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020	72 hours after death with the Maryland natural; or items 23a or 28s-f show dical Examiner must be notified at	by Funeral	11. Marital Status 1 Navar Marriad 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' ed 1 Yes 2 If Yes, Giva Yeer or Datas:	? [No		es 2 No	ispanic Origin? (Span, Mexican, Puerto Specify:	Decify Yas or No- Dican, etc.)		- American Indian, White, etc. White	
21215-0020	s within jene. r than	Completed by	15. Decedent's (Specify only highest Elementary/Secondery (0-12)	s Education grade completed) College (1-4or	5+)	6a. Decedent's (Give kind of life. DO No.	JI use ratirad		king	16b. Kind of Busi		
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Balti	permit. Pages Department of I Important: If Ite any Injury or or		21. Signature of Euparal Segue Li	densee News		22. Nam	e and Addres	ss of Facility	Home			
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29a. CERTIFIER

Due

31. DATE FILED (Month, Day, Year)
MAR 1 9 1997

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the m
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08440 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH TIME OF DEATN ahn 4:08 A 3 Irainia 4. SOCIAL SECURITY NUMBER OF b.

th, Day, h.

5, 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTN (Month, Day, Year) IF UNDER 1 YEAR | IF UNDER 24 HRS. DAYS HOURS 216-03-2183 1 M 2 X F 90 YRS. Dec. 1906 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Wesley Home Baltimore City RESIDENCE OF DECEDENT 10a, STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Baltimore City 1 🖾 YES 2 🗌 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2211 West Rogers Avenue 21209 U.S.A. 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—It yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married BY Specify 3 X Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use retired.) Social Security Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Teller Credit Union 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) BE George Vernon Wagner Sarah Buxton 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Albert Hahn /Son 32 G Bluebill Drive Selbyville, DE 19975 20s. METNOD OF DISPOSITION
1 Starte 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Woodlawn Cemetery B/20 Woodlawn, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximata Interval Between ahock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Finel **Onset and Death** disease or condition resulting in death) acute Cesper atony DUE TO (OR AS A CONSEQUENCE OF): lan rebrovascu CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate brovercu cause. Enter UNDERLYING la CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL COMPLETION OF CAUSE X NO 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO W UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL NO 1 | Inpatient 2 | ER/Outpetient 3 | DOA Nome 5 - Rasidence 6 - Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY 26b. TIME OF 28c. INJURY AT WORK? 26d. DESCRIBE NOW INJURY OCCURED 1 Natural 2 Accider Tea BY Accident 28e. PLACE OF INJURY — At home, ferm, street, tectory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 6 Could not be 4 Homicide

CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

211

PERSON WHO COMPLETELY CAPISE OF DEATH (ITEM 27) (Type, Print

ROBY

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

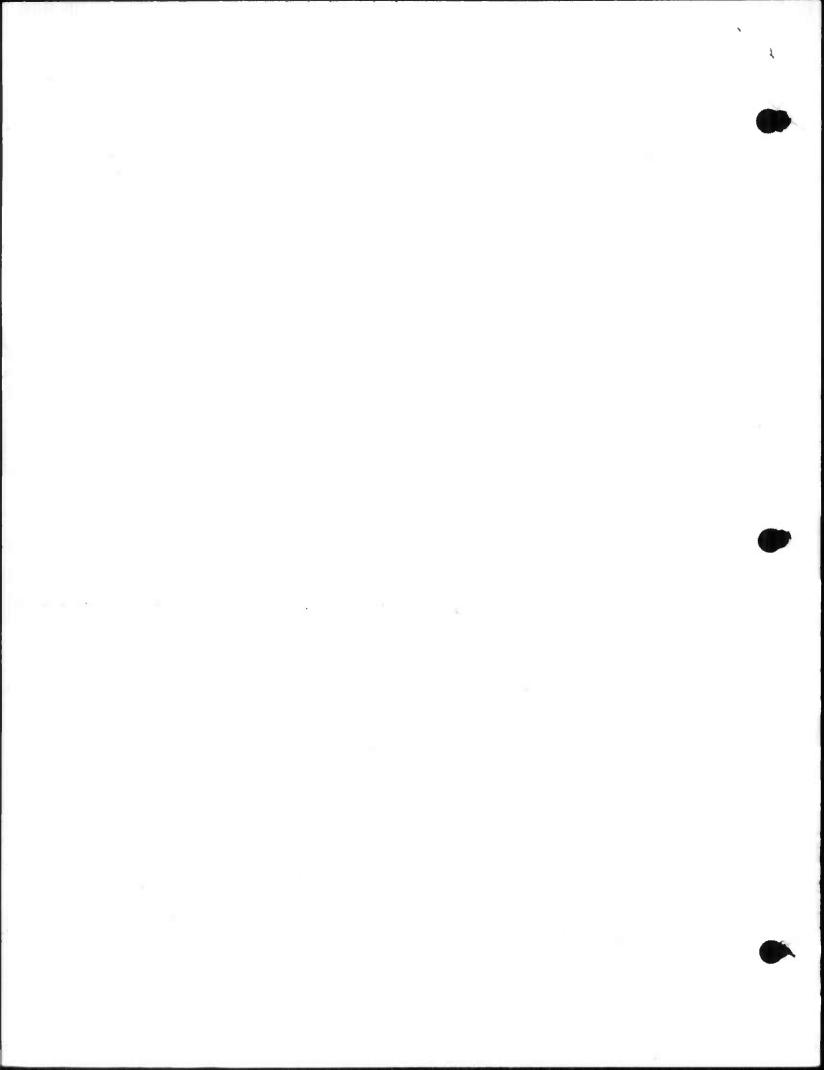
W. ROGERS

29c. LICENSE NUMBER

10

29d, DATE SIGNED (Moeth, Day, Year)

2/20



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08441 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death Month 10 14 William HampT dR MARCH 4a. Fecliity Name (If not institution, give street and number 4b. City, Town, or Location of Deeth 4c. County of Death Baltimore City Levindale Geriatric Center & Hosp. Baltimore Months Days Hours Min. 8. Dete of Birth (Month, Dey, Year) April 17, 1918 5. Sociel Security Number 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) Months Maryland Yrs 212-18-7960 78 Usual Residence of Deceden 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Pikesville 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 510 Nassau Street USA 21208 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritei Stetus 12. Was Decedent Ever In U.S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates: Black, White, etc. 1 ☐ Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 7th College (1-4or 5+) Veterans Administration Carpenter 18. Mother's Neme (First, Middle, Malden Surneme) 17. Fether's Name (First, Middle, Last) Goldie Shaffer William A. Hampt. Sr. 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) Margaret S. Hampt / wife Pikesville, Md. 510 Nassau St. 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Stete 3-20-97 Finksburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gardens 22. Name and Address of Fecility 21. Signeture of Funeral Service Licansee 11824 Reisterstown Rd. Eline Funeral Home Reisterstown, Md. 21136 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Finei END STAGE Chronic Obstructive Pulmonary Disease disease or condition resulting in death) Due to (or as e consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting In death) Lest Due to (or as e consequence of): Due to (or es a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b, Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 Yss 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

þ

10e State

Funeral

Director

tem 27 is marked other than "natural", or flems 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

permit. Peges 1 and 2 should be filed within 72 hours atter death v. Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a and Injury or other traummit's event, the Medical Examiner must once.

Baltimore, Maryland 21215-0020

with the Meryland

signed by t d be detach funeral

Records, P.O. Box 68760,

Division of

attending physician and for use as the buriel-trensit

Medical

Examiner Physician/Medical Be 20 Certification:

þ Completed

29a. Certifier

To the Hospital or Attending Physic within 24 hours after death.

To the Funerel Director: After this can

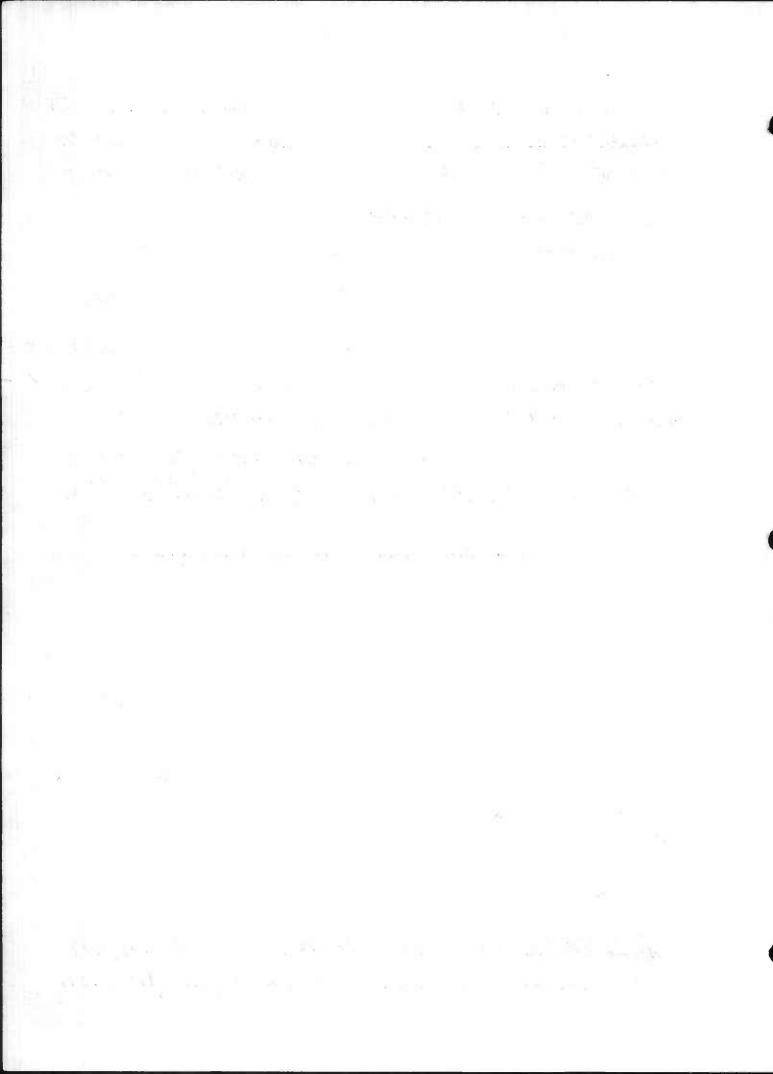
State Registrar

24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Wes an autopsy performed? 2X No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 □ ER/Outpetient 3 □ DOA 27. Manner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 1 Neturei 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigetion 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end manner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) and menner steted. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

end address of person who completed cause of death (Item 23e) (Type, Print)

2434 W. Belvedera De, Batto Md 21215 PERTHEIMER NO



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		_		State C	or Maryia		Certific			Mental H	ygiene Reg. No.	97	0841	12
	sicia: edica	ıI.	1. Decedant's Neme (First, Middle,	HODGE	_				<u> </u>	2. Dete of D Month MARC	Dey	Yeer /957	3. Time of De	
- Exa	mine ral		4e. Fecility Name (If not institution, LORIEN NURSING	give straet end nu	7. Age (In yrs		hdey) If Un Monti	der 1 Yeer		n. (Month, E	irth Day, Year)	BALTI 9. Birth	plece (Stete or F	oreign
Direct		-	Usuel Residence of Decedent 10e. State 10b. County	X			or Location			MAR 10	,1908	MARY	LAND 10d. Inside City I	imita
th the Maryi or 28a-f sho		Director	MD N/A 10e. Street end Number			LTIM	IORE	Zip Code			10g. Citize	n ol Whet Cou	Y☐ Yes 2	
ours effer death with the Marylan all, or items 23a or 28a-f show		by Funeral L	5225 GARMOUTH R 11. Maritel Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorcad	12. Wes Dec	2 No	U,S.			229 lispenic Orlgin? (en, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)		U.S. Raca - Americ Bleck, White,	can Indien,	
d within 72 hogiene.		Completed	15. Decedant's (Specify only highest Elementery/Secondery (0-12) 8TH GRADE 17. Fether's Nema (First, Middle, Li	Education grade completed) College (1		16a.		suel Occup work done Tuse retirad	during most of w d) KER	orking eme (First, Middl		of Business/In HOMEMA		
d la b		10 De	ROBERT L. CORCO	RAN					ELIZA	BETH C.	SCHUMA	AN		
C - OI -			19a. Informent's Name/Raletionshi DOROTHY E. WIBL			522	5 GARM	OUTH		Rural Route Num BALTIMOR	RE, MD	2122	9	
			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spe		State	camatery	Disposition (/ r, cremetory of HEDERA	or other plea		3/18/97		tion - City or To	own, Stete	
permit. Peges Depertment of Important: If I	9000		21. Signature of Funeral Service Li	Colone	_		HUBBA	RD FU	SS OF Fecility	OME INC.		MD 2	1229	
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aw requires to been sign 2 should be	Completed by	pieted by	CHF	ntin						24a. We	s en eutopsy formed?	av co	era autopsy find alieble prior to impletion of caus deeth?	
n: The luttinger ha	Re Co.		25. Was case raferred to medical						26 Place of De	1 □ eeth (Check only	Yes 2	1 [☐Yes 2☐ No	
or Attending Implication of the death. Institute of the tuneral death.	F	Hospitel: 1 Inpatient 2 ER/Outpetlent 3 DOA						28c. Injur Wor 1 🗆	er: 4 Narsing	rsing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
To the Hospital or Attention within 24 hours effer deel To the Funeral Director: completely filled in by the	Polical Co		29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the aminer: On the be	best of my knows of exemination	owledge, ation end	deeth occurre for investigati	ed et tha tin	ne, dete and pled pinion, deeth occ	a, end due to the curred et the time	cause(s) en	nd manner as s aca, and due to	teted. o the cause(s)	
To the within To the	Me		29b. Signature and title of certifier	r so con mani			2	29c. Licens	number			signed (Month,	Dey, Year)	
2		3	30. Nema and address of person when PETBN CH	o complated caus	e of deeth (Ita			or.	Collens	A 41				7
	State istrar		31. Date filed (Month, Dey, Year)	32. P	egistrer's Sign	eture	andella					-		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death Month 03 Day Allen Harper Sr. 12:08AM 4a. Facility Nema (If not institution, give streat and number) 4b. City, Town, or Location of Deeth 4c. County of Death 2064 Kennedy Avenue Baltimore 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Undar 1 Yaar If Under 24 Hrs. Birthplace (Steta or Foreign Country) 10M 20 F Days 218-26-9019 Yrs. 63 02-11-34 NC Usual Residence of Decedant 10a Stata 10h County 10c. City, Town or Location 10d. Insida City Limits Md. XYes 2□No NA Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2064 Kennedy Avenue 21218 USA 12. Was Decedent Ever in U,S. Armed Forcas? Was Dacadant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Biack, Whita, atc. 1 X Yas 2 No If Yas, Giva Yaer or Datas: 1 Navar Married 2/CXMarried 1 ☐ Yas 2 No Specify: Specify: Black 3 ☐ Widowad 4 ☐ Divorced 15. Dacedant's Education (Spacify only highast grada completed) 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 9th grade Laborer NA Bethlehem Steel Co. 17. Fethar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Adam Harper Alice West 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 21218 19a. Informent's Name/Ralationship (Type, Print) 2064 Kennedy Avenue Baltimore, Maryland Doris Harper 20a. Method of Disposition 20b. Pleca of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, Stata XX Burial 2 Cramation 3 Ramoval from Stete Baltimore Cemetery 03-19-97 Baltimor, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licenses 22. Nama end Addrass of Facility Baltimore, Maryland WM.C.MArch FH 1101 E. North Avenue 21202 s that caused the death. Do not enter tha moda of dying, such as cardiac or respiretory errest, se on aach lina. 236. Part1. Enter the disease, or complic shock, or heart failure. List only op Approximeta Intarval Batween Onsat and Death Immadiata Ceuse (Final HEPATIC FAILUNE disaasa or condition rasulting in daath) WEEK Dua to (or as a consequence of): CAPTER (ADSUDCIRCIPOIA MEDASTATIC ESOPHAGRAL Sequentielly list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Diseesa or Injury that Initiated events rasulting in daath) Last Dua to (or as a consequence of) Dua to (or as a consequanca of) Part II. Other algniftcant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the cause of death? 1X Yes 2 No 3 Probably 4 Unknown RENAL INSJFFICIENCY 24b. Wara autopsy findings aveilable prior to complation of causa of daath? 24a. Was an eutopsy performed? 2 NO 1 Yes 2 No 25. Was casa rafarred to medical 26. Placa of Death (Check only one) axaminar? Hospitel: Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 5 Panding invastigation 1 Netural 1 Yes 2 No 2 Accident

attending physician end for use es the burief-transit certificeta be executed P.O. Box 68760, signed by the Records. 8

Physician/Medical by Completed Be 2 Certification: Aftar

Physician

/Medicai

Examiner

Director

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Completed

Be

2

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f ahow treumatic avent, tra Modical Examiner must be notified at

Peges 1 and 2 should be filed within 72 hours eftar on neat of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or ites
Inty or other traumate avont, Ira Mental Expension

permit. Pege Depertment of Important: If any Injury or

Physician /Medicai

Examiner

Baltimore, Maryland 21215-0020

the Maryland

death

Division of Vital Physical death. ofter death filled in by the

To the Hospital or within 24 hours eff To the Funeral DI completely filled in

3 Suicida

29e. Certifier

Willson

4 Homicide

(Check only one)

29b. Signatura and titla of certifiar

31. Data filad (Month, Day, Year)

MAR 1 9 1997

6 Could not be datarminad

State Registrar

Medical

30. Nama and addrass of person who complated causa of death (Item 23e) (Type, Print)

William A. Flwss, MO THE Johns Hoffman Oncower Com

29c. Licansa number 1)44682

1 Certifying Physician: To tha best of my knowledge, daath occurred at tha time, date end plece, end due to the cause(s) and mannar as stated.
2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end mannar stated. 29d. Data signed (Month, Day, Year)

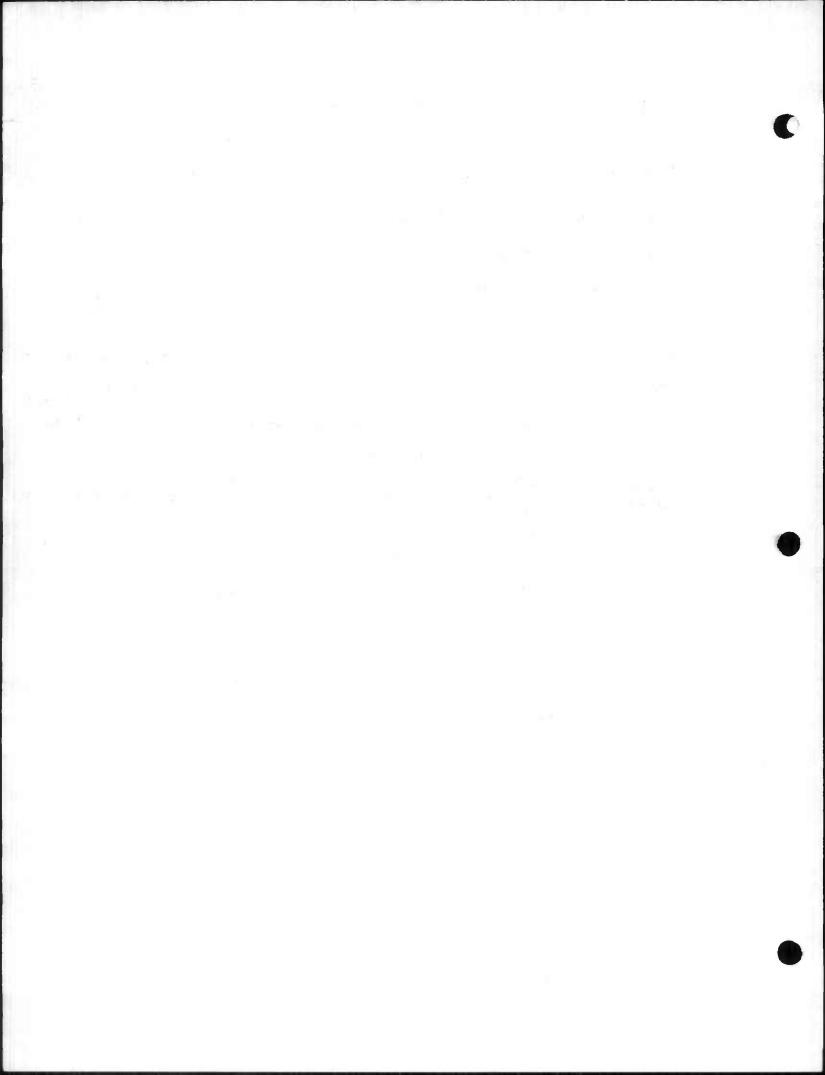
28f. Location (Straat and Number or Rural Route Number, City or Town, State)

MARCH 17, 1997 600 N. WOLKE ST

BALTAIN MA 21287

32. Ragistrar's Signature

28a. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month M. Johnson 03

Physician /Medical Examiner

Funeral Director

the Maryland 28a-f show the Medical Examiner must be notified at With 6 items 23a death filed within 72 hours after 6 "natural". than Hygiene.

permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygiene Important: if Item 27 is marked other traemy injury or other treumstic event Physician /Medical

Baltimore, Maryland 21215-0020 Examiner ires that the death certificate be executed attending physician and for use as the bunal-tran P.O. Box 68760. signed by the aid Records, of Vital Hospital or Attending Physic this Division After To the Hospital of within 24 hours all To the Funeral D completely filled

Gladys 0705 4a. Facility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Chestertown Chestertown Nursing E. Rehab center kent 5. Social Sacurity Number If Under 1 Yaar | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yaar) 1 1 / 2 7 / 1909 6 Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country)
 M D 1□ M 2 F Months Days 87 188-36-9674 Usual Rasidance of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits MD. Director Kent 1 ☐ Yas 2 ☑ No Chestertown 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 225 Richard Dr. 21620 U.S.A. Funeral 12. Was Dacedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 11. Marital Status 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 1 Nevar Marriad 2 Married 1 Yas 2 No Specify: White þ 3 Widowad 4 □ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Dacedant's Education 16b. Kind of Businass/Industry (Specify only highest grada complated) Elamantary/Secondary (0-12) Collaga (1-4or 5+) 12 Homemaker Own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maldan Sumama) Be Frank L. Mohler Lillie Broun 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, State, Zip Coda) Mary Lane MacVay/Daughter 225 Richard Dr. Chestertown, MD. 21620 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 3/21/97 Pittsburgh, PA. 21. Signatura of Europea Sarvice Licansee 22. Nama and Addrass of Facility Sterling Ashton Funeral Home, 736 Edmondson Ave. Balto., MD. Inc. 21228 23a. Part 1. Enter tha disease, or complication, but caused tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death Immadiata Cause (Finel COLORDIE HERMI PARCINE disaasa or condition resulting in daath) Due to (or as a consaquanca of) Examiner Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiated evants resulting in daath) Last Dua to (or as a consequence of): Physician/Medicai Dua to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco usa contributa to the causa of death? 1 Yss 2 No 3 Probably 4 ☐ Unknown þ Completed 24a. Wes an eutopsy performed? 24b. Were autopsy findings available prior to completion of causa of deeth? 1 ☐ Yas 2 ☐ No Be 25. Was casa rafarrad to medical axaminar? 26. Placa of Death (Check only ona) 1 Yas 2 No Other: 2 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Othar (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatiant 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred Certification: 1 Natural 5 Panding Invastigation 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be datarminad 3 ☐ Suicida 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida Cartifying Phyalcian: To the bast of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. 29a, Cartifiar Medicai

29c. License number

11-132-24

Rd. Suite 5 Chestertown, MD. 21620

29d. Data signed (Month, Day, Year)

State Registrar 29b. Signatura and titla of certifiar

31. Data 1 1 2 2 7 1 9 1 9 1

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Seymour, M.D. 122 Speer

30. Nema and addrass of person who completed cause of daath (Itam 23e) (Type, Print)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 9 7

1. Decedent's Name (First, Middle, Last) **Physician** 10450Ur1 Varan 16 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Baltimore Center 6601 N. Charles. Baltimore SICHIST Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

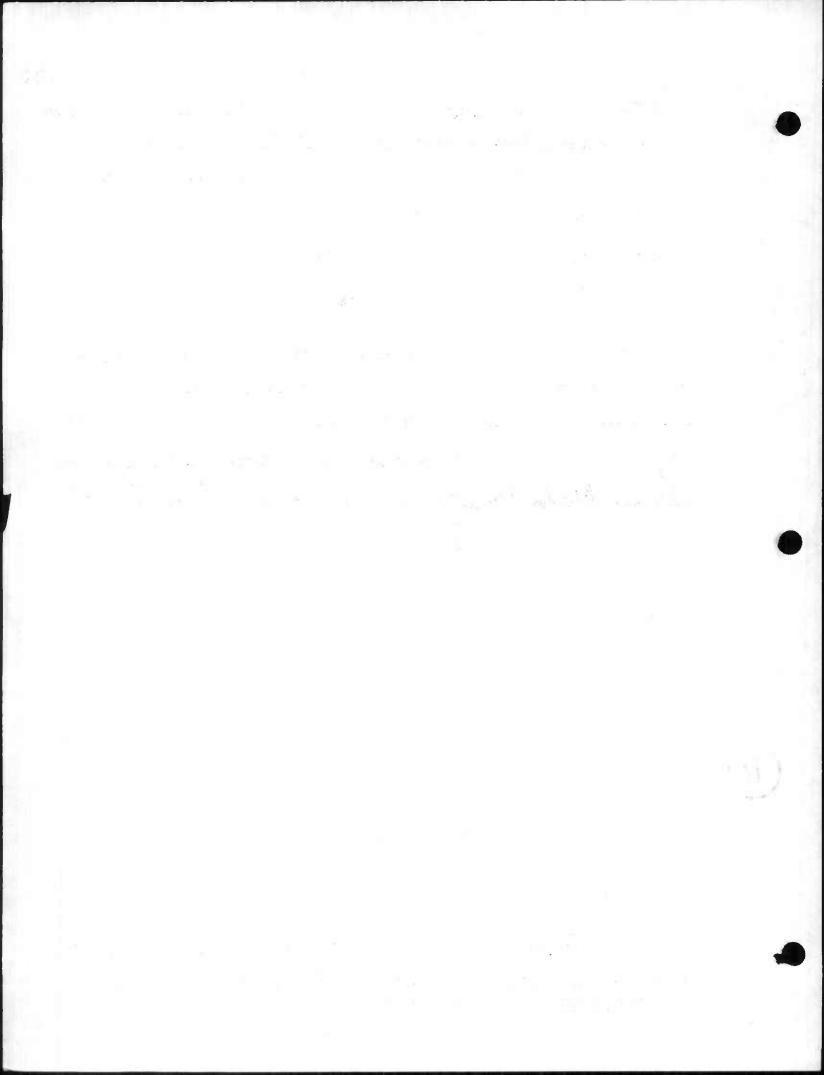
June 27, 1927 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplece (State or Foreign Country) Months Days Hours Director Yrs. 220-12-9208 Maryland with the Manyland 10a. State 10b County 10c. City, Town or Location mass or 28a-f show 10d. Inside City Limits Maryland N/A Director Baltimore XX Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2817 Elliott St 21224 Funeral death USA Hems ! 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes X2X No If Yes, Give Yeer or Dates: 11. Maritei Status Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Peges 1 and 2 should be filed within 72 hours after a Deportment of Health end Mentai Hygiene. Important: if item 27 is marked other than "natural, or item any injury or other traumatic event, the Medical Experiments. Black, White, etc 1 ☐ Never Married XX Memied 21215-0020 þ 1 Yes 2/XX Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Customer Relations Leasing Company Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be Blatchlev Harry ပ Elsie Buckingham 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David J. Kousouris 1909 Falls Road Son 21120 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other placa) Date 20c. Location - City or Town, State XX Jurial 2 Cremetion 3 Removal from State Donation 5 ☐ Other (Specify) Parkwood Cemetery 3/18/97 Baltimore, MAryland sture of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Home 23a. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one buse on each line. 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Deeth Physician /Medical immediate Cause (Final CANCER disease or condition resulting in death) Examiner Due to (or as a consequence of) Examine res that the death certificete be executed use es the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last and Due to (or es e consequence of): P.O. Box 68760, ettending physician Physiclan/Medical Due to (or as a consequenca of): ed by the e Part il. Other significant conditione contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown peudi Records, by Be Completed 24e. Wes en autopsy performed? 24b. Were autopsy findings evailable prior to completion of cause of death? 2 2 No 1 ☐ Yes 1 ☐ Yes 2 No Division of VItal 25. Was case referred to medical exeminer? 26. Piece of Death (Check only one) or Attending Physic 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 MOther (Specify) INPT 1105Pts Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of injury (Month, Day Year) 27. Manner of Death 28c. injury et Work? 28d. Describe how injury occurred 28b. Time of After t 5 Pending investigation 1 Natural within 24 hours efter death.

To the Funeral Director: Af
completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital to Sertifying Phyalcian: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. Medical (Check only the 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Yeer) March 16, 1996 30. Name end address of person who completed cause of death (item 23a) (Type, Print).

LITA PABLA 6565 N. Charles St St 203 Baltomo Re MD 2120+

State Registrar

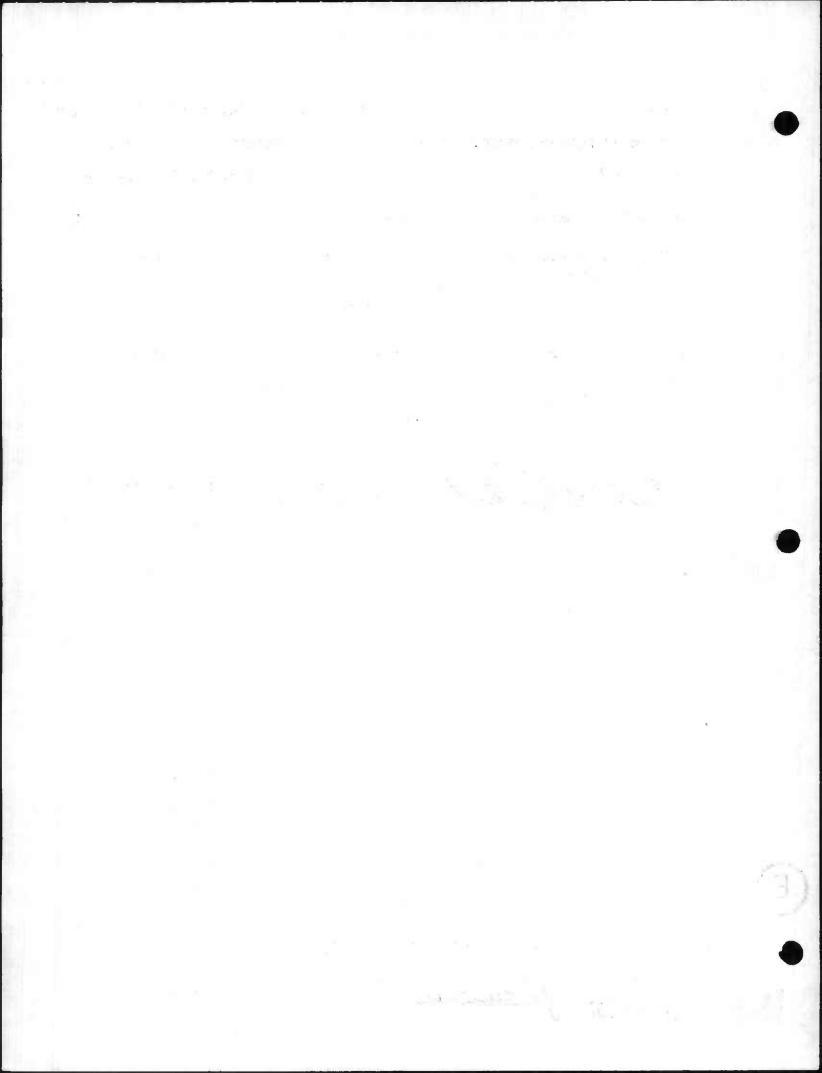


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sician edical	1	1. Decedent's Neme (First, I					Kler	gus.	2. Dete of Dec Month Much	Peth 13 19	9 ^{Year}	3. Time of Death
miner	_	4e. Fecility Neme (If not Insti	tution, gi	ve street end nuπ	nber)			City, Town,	or Location of Deeth	4c. County	of Deeth	
ral tor		PENINSULA R 5. Social Security Number 146-32-4874	6.		7. Age (In yrs	ENTER s. lest birthday) 55 Yrs.	If Under 1 Yea Months Dey	ar If Under 24 H	ISBURY Irs. 6. Date of Birt (Month, De) Oct. 25	h y, Year)		ece (Stete or Foreign
		Usuel Residence of Deceder	nt						OCL. 23	,1941	unkno	WII
		10e. State 10b. Co	unty		10c. C	city, Town or Lo	ocation				100	d. Inside City Limits
Director	3	Maryland W	com	ico	S	alisbuı	Ту					1 XYes 2 □ No
1	5	10e. Street end Number					10f. Zip Code			10g. Citizen of	Whet Countr	y?
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by Funeral Director	2	11. Maritel Status unkno 1 □ Never Merried 2 □ 3 □ Widowed 4 □ Divo	Married	12. Wes Dece Armed For 1 Yes If Yes, Give Year or Da	ces? unk 2 □ No	nown	Was Decedent of f Yes, specify Cu 1□Yes 2□N unknown	iban, Mexican, Pu o <i>Specify:</i>	(Specify Yes or No- erto Rican, etc.)	14. Rad Bla Specif	ck, White, et White Whi	ic.
e e		15. Deci (Specify only h	dent's E	ducation ade completed)		16e. Deced	fent's Usuel Occ	upetion	vorking	16b. Kind of B		
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	- 1	19a. Informent's Neme/Rele unknown	ionsnip (Type, Print)				et end Number or	Rurel Route Numbe	r, City or Town,	Stete, Zip C	Code)
	\vdash	20a. Method of Disposition			20h	unkr	Sition (Name of		Dete	20e Leasting	Chy as Ta	m State
	1	1 ☐ Buriel 2 ☐ Cremet	lon 3 [Removal from S	tate	cemetery, crer	netory or other pi	lece)	Dete	20c. Location -	ony or low	11, 3(8(8
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once.				Van Sa	at 1	- 2	Name and Add	atomy Bo	ard, 655	W. Balt	imore	Street
	1	Sa. Part1. Enter the disees shock, or heart feilure.	5-1	an fe	M	I	Baltimor	e, Maryl	and 2120	1		Approximete Intervel Between
VMedical Examiner		Sequentielly list conditions, feny, leading to Immediate cause. Enter Underlying Cesses (Disease or injury that initiated events esulting in death) Lest	{	b. S.c. G	Due to (or es e consequence es	uence of):		nastri			
Physician/M	F	Pert II. Other significant con-				sulting in the ur	derlying cause g	iven in Pert I.				he cause of death?
à	-		U	rosy	2120				1 D Y	'es 2□No	3 Probei	bly 4 Unknown
Completed	-								24e. Wes a perfor		eveile	e autopsy findings eble prior to bletion of cause ath?
E									1 Y	es 200 No		
Be C	2	5. Wes case referred to med	lical					26 Place of D	eeth (Check only or			Yes 2□ No
0		examiner?		Hospitel: 1 Min	patient 2	ER/Outpetien	3□ DOA O	thor:	Home 5 Reside		er (Specific)	
n: T	2	7. Manner of Deeth		28e. Dete of (Month,		28b. Time of	28c. inju		28d. Describe h			
atio		1 Naturel 5 Per 2 Accident inv	nding estigation		Doy 1 ear)	Injury		ork?]Yes 2 □ No	- 1			
Certification:			uld not be ermined	269. Place 0	f Injury - At h	ome, ferm, stre	et, fectory, office		28f. Location (Si City or Town		er or Rurel F	Route Number,
edical C	2	9e. Certifier 17 Certi (Check only one) 2 Medi	fying Ph cai Exan	ysician: To the basend menne	is of examine	wledge, deeth	occurred et the t estigation, in my	ime, dete end plac opinion, death oc	ca, and due to the courred et the time, d	ause(s) end ma ete end pleca, o	nner as state	ed. ne cause(s)
N N				911011191119	JIOIOU.							
	2	9b. Signeture end title of car	lifier				29c. Licen	se number	2	9d. Dete slane	d (Month. De	v. Year)
	2	9b. Signeture end title of car	tifier	40 ()	· Juse	M	1			9d. Dete signed	(Month, De	y, Year)
		· De	ou	completed sauce	. Susc	M 239) (Time 1	D (4733	0	3 13	(Month, De	y, Year)
		9b. Signeture end title of car On Name end eddress of person	crucion who		of death (Item	n 23a) (Type, F	D (4733		3 13	(Month, De	ny, Year)

Registrar

State 31. Dete filed (Month, Dey, Year) July Bull-distrar's Mark 1 9 1997 July Bull-distrar's Markets



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08447 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1997 Herbert A. Knokerle March 16, 6:00 PM 4b. City, Town, or Location of Deeth 4c. County of Death Fallston Harkord If Under 1 Yeer H Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 1 M 2 □ F Months Deys 78 Yrs. Dec. 14,1918 Maryland 10h Counts 10c. City, Town or Location Fork 10f. Zip Coda 10g. Citizen of Whet Country? 21051 U.S.A. 12. Was Decedent Ever in U,S. Asped Forces? 1 M Yes 2 □ No If Yes, Give Yaar or Dates: WW 77 Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 14. Reca - American Indian, Bleck, White, etc. 1 ☐ Yes 2 💢 No Specify: White Specify: 16b. Kind of Business/Industry



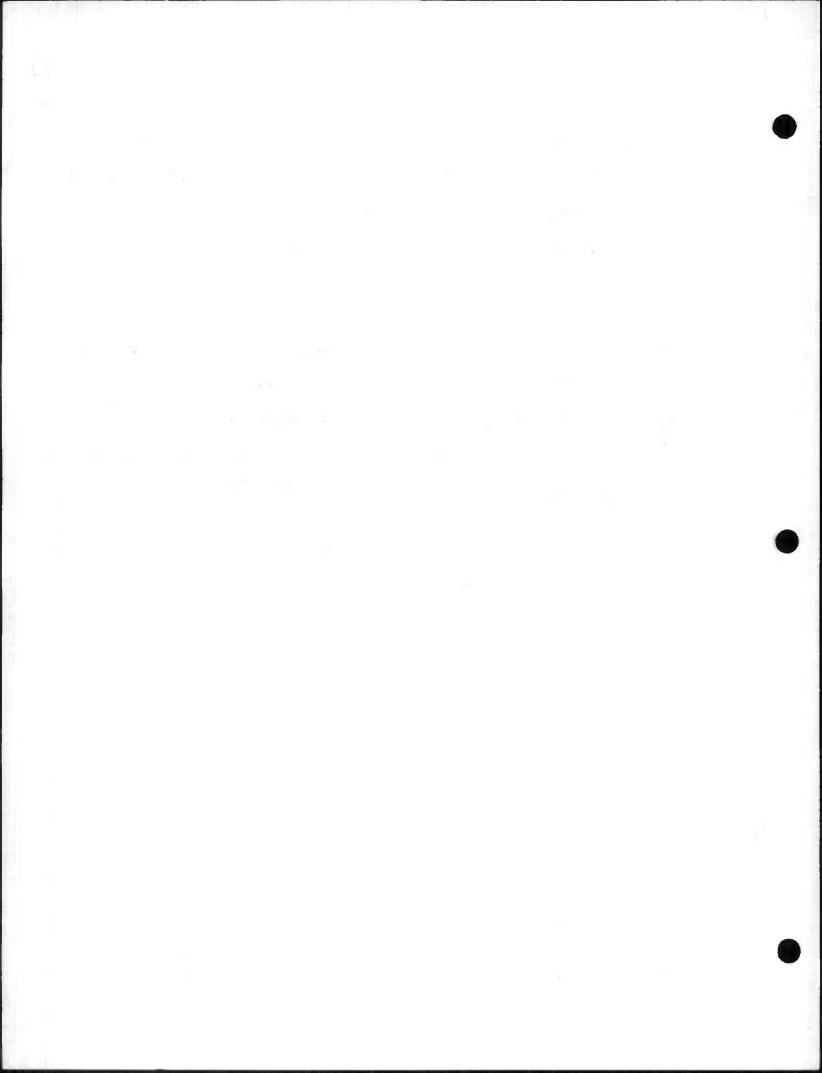
who completed cause of death (Item 23a) (Type, Print) 2/12 BAM NA

32 Resignasifiandale

MARYLAND

State Registrar

Physician

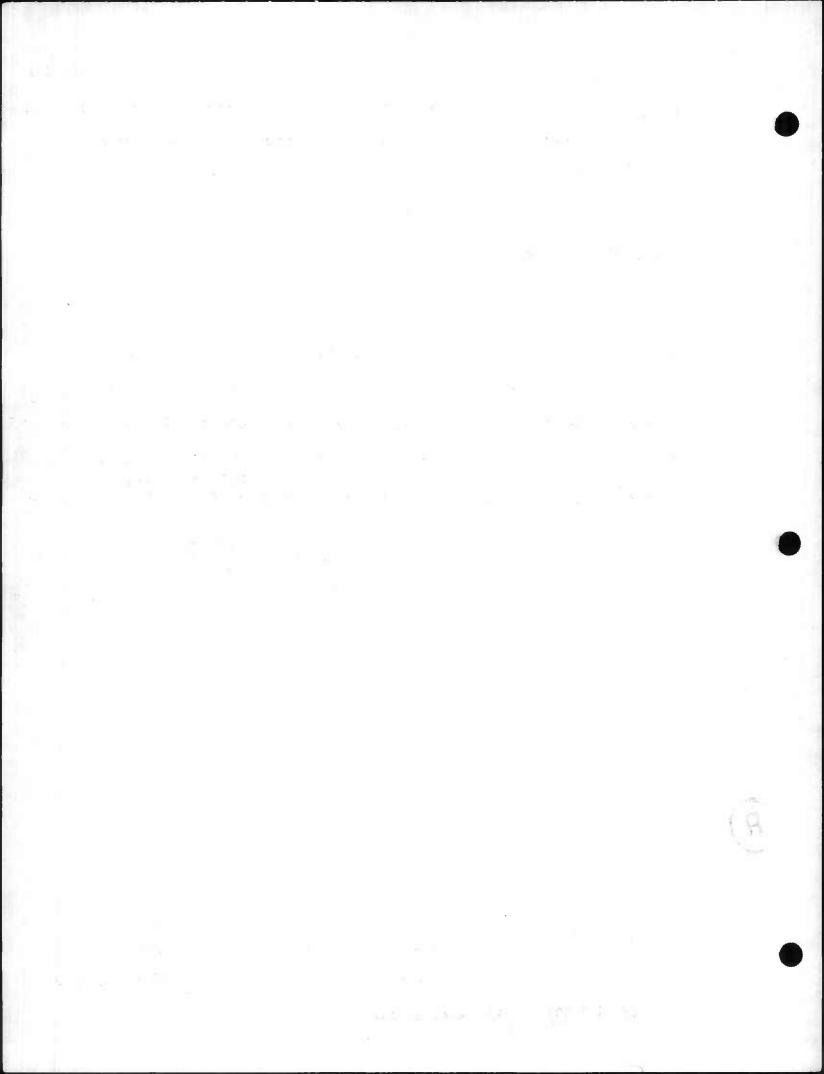


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 16b Per FH Film G745 3-18-97 rja Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death **Physician** Month ISABELLE KNIGHT MARCH 15 1997 5:20 PM /Medical 4a. Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Yaer If Under 24 Hrs.

Months Days Hours Min. 5. Sociel Sacurity Number 9. Birthplace (Stete or Foreign Country)
MD . 8. Data of Birth (Month, Day, Year) 07-06-23 **Funeral** 214-24-9629 1□M 21 F Director Usual Rasidance of Decadant the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examiner must be notified at Md. NA Baltimore 1 Yas 2 □ No Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 813 Beaumont Avenue 21212 USA Funeral 12. Wes Dacedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Giva Yaar or Datas: Was Decedant of Hispenic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxicen, Puarto Rican, etc.) Race - Amaricen Indian, Biack, Whita, etc. 72 hours efter 1 Nevar Marriad 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Ď 3 ☐ Widowed 4 ☐ Divorced Specify: Black 15. Decedant's Education (Spacify only highast grade complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry permit. Pages 1 end 2 should be filed within Department of Health end Mental Hygiene. Important: If item 27 is marked other than "e any injury or other traumatic event." London Elamantary/Secondary (0-12) Collega (1-4or 5+) Loundon Fogg Co. 5th Grade Na Clothing Examiner 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maidan Sumeme) Elmo Elizabeth Rollins Young 19a. informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 2700 N. Rosedale Street Baltimore, Maryland Florence Lewis 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata Buriei 2 Cramation 3 Removal from Stata Arbutus Mem. PK. Cem. 03-20-97 Arbutus, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Baltimore, Maryland 21. Signatura of Funda Sarvice Licensee WM.C.March FH 1101 E. North Avenue 21202 23a. Pert1. Entur the disease, or complications the caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or floar failure. List only one cause on each line. Approximete Intarval Batween Onsat and Death **Physician** /Medical immediata Causa (Final Cardiopulmonary Arrest 20 mins disaasa or condition rasulting in daath) Examiner Coronary Artery Disease Severe and Sequentially fist conditions, if any, laading to immadiate ceuse. Enter Underlying Cause (Disease or injury that initiated avants rasulting in death) Lest Dua to (or as a consequence of) Generalized Box 68760. attending physician for use es the burie Physician/Medical Amputations Pert ii. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yee 2 No 3 Probably 4 Winknown þ The law requires 24b. Ware autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy parformed? Completed hes 1 Yas 2 No 1 Yes 2 No Division of Vital Be 25. Was cesa refarred to medical axaminer? 26. Piaca of Death (Check only ona) 1 Yas, 2 No Other: 4 Nursing Home 5 Rasidance 6 Other (Specify) Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Deeth 28a. Data of injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. fnjury at Work? 1 Naturel 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be datarmined 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 3 Sulcida 28a. Place of Injury - At homa, farm, streat, fectory, office building, atc. (Specify) 4 - Homicida 6 To the Hospital or within 24 hours eft To the Funerel Dis completely filled in 1 Cartifying Physician: To tha bast of my knowledga, daath occurred et the tima, deta and place, and due to the ceuse(s) end menner es stated. Medical 29a. Cartifian 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29b. Signature and title of certified 29c. Licanse number 29d. Data signed (Month, Day, Year) 30. Nama and address of person who completed causa of death (itam 23a) (Type, Print) Suite N. Charles St. Towson 605 6565 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State MAR 1 9 1997 galia Davidson Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08449 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month 4:50 ans 4a. Facility Name (If not Institution, give straet and number) 14 97 Kricker March 4b. City, Town, or Location of Death 4c. County of Death If Under 24 Hrs. 8. Data of Hours Min. (Month, Charlestown Care Center Baltimore If Undar 1 Yaar 8. Data of Birth (Month, Day, Year) 11/17/1910 5. Social Security Number 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foreign Country) L A Months Days 1 M XXF 228-62-7051 Vrs 86 Usual Residence of Decadent 10c. City, Town or Location 10b. County 10d. Inside City Limits Baltimore Catonsville 1 Yas 2 No 10e. Street and Numbe 10f. Zip Coda 10g. Citizen of What Country? 715 Maiden Choice Lane 21228 U.S.A. 12. Was Decadant Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amaricen Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yas 2 No If Yes, Give White 1 ☐ Yes 2 No 3 Widowed 4 Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Interior Designer Decorating 17. Fether's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumame) Joseph Alexander Handy Rosa Kreiter 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 2 8 19a. Informant'a Name/Relationship (Type, Print) William Kricker/ Husband 715 Maiden Choice Lane HV302 Balto., MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 3-15 Beltsville, MD. 21. Signatur y Funeral Service Licansee 22. Name and Address of Facility Sterling Ashton Funeral Home, laules 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 736 Edmondson Ave. Balto., MD. 21228 tmmediate Ceuse (Finel disaase or condition resulting In death) End Stage Parkinson Disease year s Due to (or as a consequence of): year s Dementia Due to (or es e consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

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To the Hospital within 24 hours — To the Funeral Directon pletely filled in b

Box 68760

Vital Records, P.O.

Examiner

Physician/Medicai

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Completed

Certification:

Medical

Physician

/Medical

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MD.

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f shov traumstic event, the Medical Examinar must be notified at

permit. Peges 1 and 2 should be filed within 72 hours effer c Department of Heelth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examine, pages.

Baltimore, Maryland 21215-0020

the Marviar

death

Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part i.

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

24b. Were autopsy findings available prior to completion of ceusa of death? 1 Yes 20 No

25. Was casa referred to medical examiner?

1 Yes 2 No 27. Mennyer of Deeth 1 Naturat

5 Pending

6 Could not be determined

28a. Date of Injury (Month, Day Year) Investigation

Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Deeth (Check only one)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 - Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piece, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and mannar statad.

29b. Signatura and title of certifiar

29c. License number

29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Mes

D51051

March 14

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andres 31. Date filed (Month, Dey, Year) MAR 1 9 1997

711 Maiden choice lane, Catonsville, MD, 21228 SaLazar 32, Begistrar's Signature

State Registrar

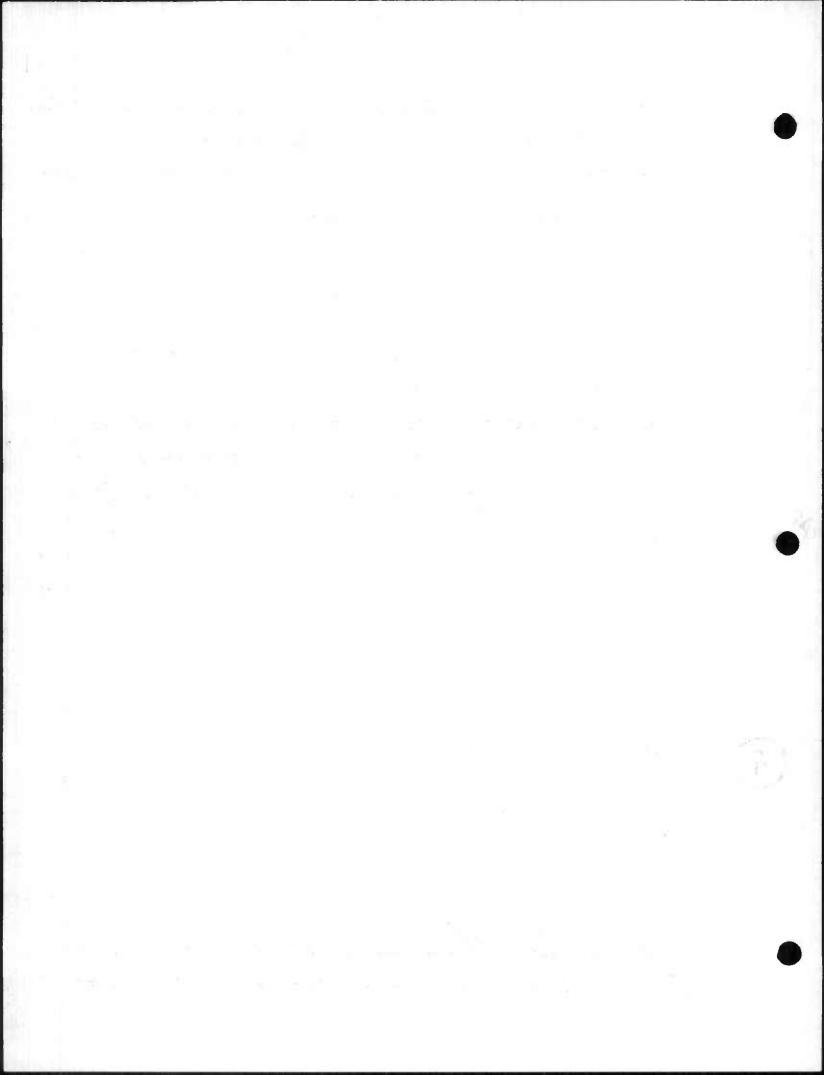
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н	Physic	ian	1. Decedant's Nama (First, Middla, Las					2. Data of Dea Month		Yaar 3.	Tima of Death
	/Medi		Charles W. Kn		•				14,199	7 3	:45 P.M
	Examii	ner	4a. Facility Nama (If not institution, give			- 4	4b. City, Town, or i Baltin			of Death timor	
-			1110 Washingto 5. Social Sacurity Number 6. S.			Undar 1 Yaar	If Undar 24 Hrs.				
	Funeral Director			XM 2□F 62		onths Days	Hours Min.		Year) 3,1934	9. Birthplaca Country) Virg	(State or Foreign inia
	land		10a. Stata 10b. County	100	City, Town or Location	on				10d. 1	Insida City Limits
	Mary Hish	ō	Md. Balti	more	Rosedal	e					1 ☐ Yas 2 💢 No
	128e	Je C	10e. Street and Number	-	1	10f. Zip Coda		-	Og. Citizen of V	Vhat Country?	M
	h with	0	1110 Washingto	n Irving	Lane	2122	20		U.S.A		
020	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Evar Armed Forcas? 1 X Yas 2 No If Yas, Giva Yaar or Datas: A		Decedent of Has, specify Cube	lispanic Origin? (S an, Maxican, Puart Specify:	pecify Yas or No- o Rican, atc.)		e - Amarican Ir kk, Whita, atc.	
9	2 hou	8	15. Decedant's Ed	ucation	16a. Dacedant	's Usual Occup	atlon		16b. Kind of Bu		
21215-0020	hin 7.	Completed	(Specify only highast grade Elamantary/Secondary (0-12)	da complated) Collega (1-4or 5+)	(Giva kind	d of work dona o NOT usa retired	during most of wor	king			
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pu	al Hy	Be	17. Fathar's Nama (First, Middla, Last)					na (First, Middla,		a)	
yla	Ment Ment arked arked	10	Charles W. Kr	lowles, Sr			Calua	Franc			
Maryland	2 sho		19a. informant's Name/Ralationship (7				and Number or Ru				
	and lealth m 27 her tu		Rose Marie Kr				igton I				
Baltimore,	permit. Peges 1 and 2 Department of Health s Important: If Item 27 is any Injury or other tra pncs.		20a. Mathod of Disposition TV Bunal 2 Cramation 3 4 Donation 5 Othar (Specify	Ramoval from Stata	Ob. Place of Disposition cometary, cremate HOILY Hi	on (Nama or Doy or othar place II Men	d. Gar.	3-18-9	20c. Location - 7 Balt	City or Town,	Stata
Ball	permit. Pege Department of Important: If any injury or once.		21. Signature of Therail Service Loen 23a. Part 1. Entar tha diseasa, or counshook, or heart failure. List care	21	22. Na Bra	ama and Addra	ss of Facility Ashton l	uneral	Home,	Inc.	01000
	_		23a. Part1. Entar tha diseasa, or court	ications that caused tha	daath. Do not antar th	A Will na moda of dyln	ow Spr	or respiratory are	,Balto	Apr	21222 proximata
	Physician /Medical Examiner		Immediata Causa (Final disaasa or condition rasulting In daath)	a. Casc	enemce le to (or as a consequan	ng			L TE		yriu mt
	7 5	ner		Dua	to to as a consequent	THE PARTY OF THE P					
o,	hat the deeth certificate be executed at by the attending physician and distanced for use as the bunet-transit	Examiner	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury	b. ——Dua	to (or as a consequan	ce of):					
68760,	ifficate be g physicil es the bu	edical	Causa (Disease or Injury that initiated evants resulting in death) Last	c. Dua	to (or as a consequand	ce of):					
Box	esth certif attending I for use e	N/UK		d							
Э.	the att	sich	Part II. Other significant conditions co	ntributing to death but no	rasulting in tha undar	fylng causa giv	an in Part I.	23b. Did to	obacco use cor	ntribute to the	cause of death?
P.O.	that the de ed by the deteched	/ Physician/M						1 🖭	ea 2□ No	3 Probably	y 4 Unknown
sp		d by						24a. Was a	n autopsv	24b. Wara a	utopsy findings
Reco	R	Completed						perfor		avallab	le prior to ition of causa
	- 3 4						_	1□ Y	as 2 Ho	1□ Ya	s 2DNo
of Vital	Physician: this certific ral director,	Be	25. Was casa rafarred to medical axaminar?	Hospital:		Oth	ar	th (Check only or			
of	Phys this ral di	- T	1 ☐ Yas 2 ☐ MO	1 ☐ Inpatiant	2 ER/Outpatient 3	3LI DOA	4 LI Nursing H	oma 5 D nasid			
		tion	1 □ Natural 5 □ Panding	(Month, Day Yea	r) Injury	28c. Injun World	k? Yas 2 □ No	260. Dascribe II	ow injury occur	0 0	
Division	Hospital or Attanding 24 hours efter death. Funeral Director: After Nely filled in by the fune	Certification:	2 Accidant Invastigation 3 Sulcida 6 Could not be 4 Homicida datarmined	28a. Place of Injury - building, atc. (S)	At homa, farm, street,			28f. Location (S City or Town	treet and Numb n, Stata)	er or Rural Ro	uta Number,
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☐ Medicat Exam	rsician: To the best of my Iner: On the bests of exer and mannar stated.	knowledga, death occ nination and/or invasti	curred at the timigation, in my of	na, data and place pinion, daath occu	, and dua to tha c rred at tha tima, d	ausa(s) and ma ata and place, a	nnar as stated and dua to tha	causa(s)
	Withir To the	Me	29b. Signature and title of certifier			29c. Licans	a number	2	9d. Data signed	(Month, Day,	Year)
	1.1		► WW	MD		DIE	5487		3/17/	97	
	VXI		30. Nama and addrass of parson who c	omplated causa of death	(Itam 23a) (Type, Prin	_1	10'		1.1	('	
	Sta	to	MYO THANT 31. Data filed (Month, Day, Year)	6830	HOSPITAL	DRIVE	STE	206	BACT	U, MI	21237
	Poglet	ne -	MAD 1 9 1007	Gran Day	Ignatura Pandess	-					

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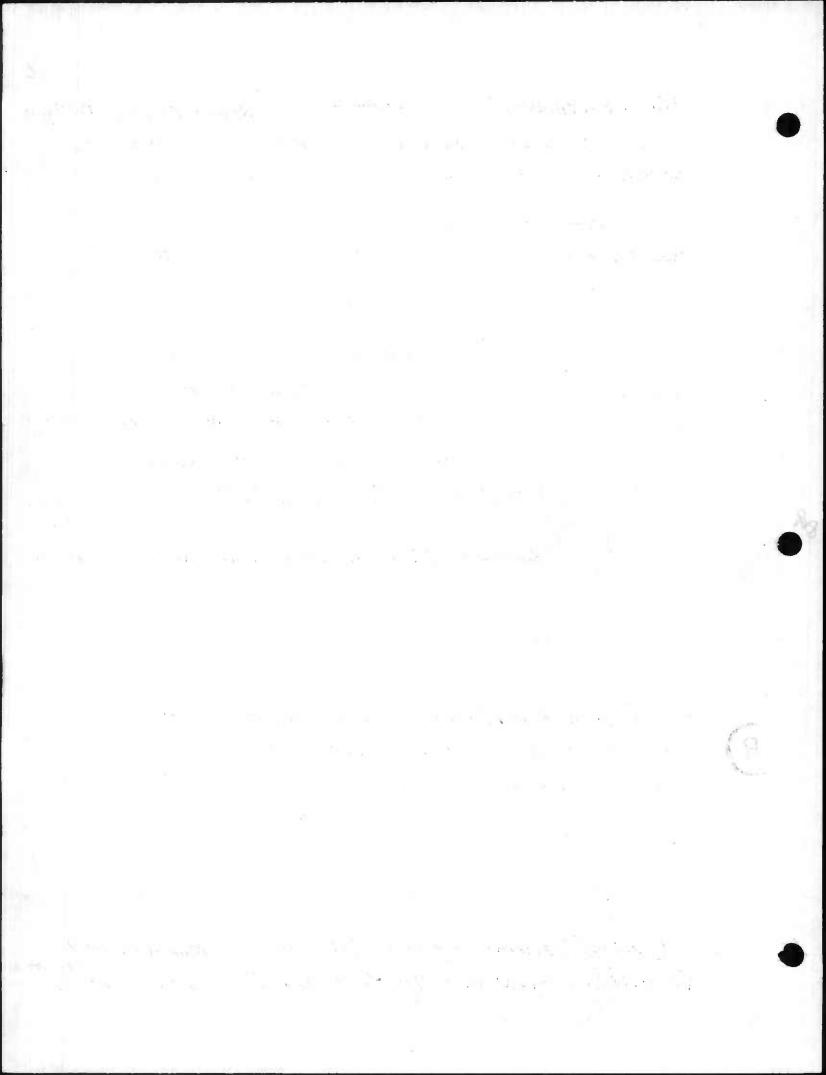
State of Maryland / Department of Health and Mental Hygiene

	ten	20a per FH Film G		a	Certificate of	of Death		g. No. 9 /	08451
Physici /Medic		1. Decedent's Nama (First, Midd FANN IE	le, Last)	K	1412		2. Data of Deeth Month	Day Year 16 1997	3. Time of Death
Examir	er		n, giva street end numbe	ar)		11/11/11	none	4c. County of Deat	h 7
Funeral Director		5. Social Security Number 217–12–7054	6. Sax 1 □ M 2 💢 F	Aga (In yrs. last bir 89	thday) If Under 1 Ya Months Day	ar If Under 24 Hrs. ys Hours Min.	8. Data of Birth (Month, Dey, MAY 14,	9. Birt 1907	hpleca (Stata or Foraign untry) POLAND
n the Maryland r 28a-f show	tor	Usual Rasidanca of Dacadant 10a. Stata 10b. County MD	N/A	10c. City, Tow	or Location	MORE			10d. Inside City Limits 1 Yes 2 □ No
th with the 23e or 28s	al Director	10e. Street and Number 2500 W. BELVED	ERE AVE.	#805	10f. Zip Cod	21215	10	g. Citizen of What Co	untry?
5-0020 72 hours after death with the Maryland 72 hours after death with the Maryland natural; or Items 23e or 28=1 show after Examiner must be notified at	by Funeral	11. Meritel Stetus 1 Never Married 2 Mar 3 Vidowed 4 Divorced	If Yes Give	s?] No	13. Was Decedant of If Yas, specify C	of Hispanic Origin? (Spe uban, Maxican, Puarto I No Specify:	cify Yas or No- Rican, atc.)	14. Raca - Ama Black, White Specify: W	
within with	Completed	15. Dacedar (Specify only higha Elamantery/Secondary (0-12) 12	it's Education st grada completed) Collega (1-40	or 5+)	Decedant's Usual Oct (Giva kind of work do lifa. DO NOT use ret HOUSEWIFE	na during most of working	ng 1	6b. Kind of Business/	Industry
be file had othe event	To Be Co	17. Fether's Nama (First, Middla, SOLOMON	Last)	СОН		18. Mothar's Nema	(First, Middla, M	OWN HOME faiden Sumeme) SAVARIN	
d 2 should th and Mer 7 is marke trsumatic	-	19e. Informant's Name/Ralations	ship (Typa, Print)			eet end Number or Rura	l Routa Number,		Zip Code)
s 1 an r Heat tem 2 other		SANDY PERTNOY 20a. Mathod of Disposition 1 (\$\frac{1}{2}\text{Burial} 2 \text{Cramation} 4 (\$\frac{1}{2}\text{Continuous} = \frac{1}{2}\text{Continuous}	3 □Ramoval from Stat	20b. Placa of cematar	501 NORTHR Disposition (Nema of y, cramatory or other p	olaca)		ORE, MD 21 Oc. Location - City or BALTIMORE	Town, Stata
permit. Pages 1 ar Department of Hea important: if item: eny injury or other		4 Donation 5 Other (S		H.	22. Nama and Ad				
Hell F		23a. Part 1. Enter the disease, or shock, or haart failure. List	complications thet caus only ona ceusa on aach	ed tha daath. Dor					Approximate Interval Batween Onset and Death
Physician /Medical Examiner		fmmediata Cause (Finel disease or condition resulting in deeth)	e. S	EPSIS				1	
	Jeu		0.	Due to (or es a	consaquanca of):			}	1 MONTH
rifficate be executed ng physician and as the burlat-transf	Medical Examine	Sequentielly list conditions, if any, laading to immadiata causa. Enter Underlying Ceusa (Disaesa or Injury that initiated avants rasulting In death) Last	b	Due to (or as a c	onsequance of):			1	1 /10~11
e death oe the attends	sician/	Part II. Other significant condition	d	but not rasulting tr	tha undarlying causa	givan In Part t.	23b. Did tot	pacco uae contribute	to the cause of death?
d by beland	y Phy	Myocaroin INF	ARCTIONS,	CONCESTIO	E HEART	FALLURE,	1□ Ye	8 2 No 3 P	robably 4 Unknow
P	Completed by Physician/	HYPERTENSIE	in, Cunon	11C RENI	re FAIL	une	24a. Was an perform	ed?	Wara autopsy findings eveilabla prior to complation of cause of daath?
10 Page 1	Be Con	25. Was casa rafarred to medica				26. Pleca of Death	1 ☐ Yas		1□ Yas No
After this certifundrial direction	2	examiner? 1 Yes 2 No 27. Manper of Death 1 Neturat 5 Pandir		jury 28b. T	ima of 28c. tr	Other: 4 Nursing Hon njury at 2 Vork?	na 5□ Rasidar	nca 6 □Othar (Spec w Injury occurred	cify)
To the Hospital or Attending Physical Williams (1997) within 24 hours although of the Purental Director After this completely filled in by the fundral di	Certification:	Accident invasti	not be 28e. Placa of I	njury - At homa, fa atc. (Specify)	m, straat, factory, office	☐ Yes 2☐No	8f. Location (Str. City or Town,	eat and Number or Ru Stata)	urai Route Number,
To the Hospital or within 24 hours aft To the Funeral Dir completely filled in	edical (29a. Certifier Cartifyin (Check only 2 Medical	g Phyalcian: To tha bes Examiner: On the basis and mannar:	of axamination and	death occurred at the l/or Invastigation, In m	tima, data and ptece, e y opinion, daath occurre	nd due to the cal d at the tima, de	use(s) and mannar as te and placa, and dua	stated. to the causa(s)
To the within 2 To the comple	M	29b. Signature and Hits of certifia	0,	1		ansa number		d. Data signad (Monti	
5		30. Name and addrass of person	17	daath (Itam 23a) (Type, Print)	402321EC	1005 19	BOLLANCE	1971
Sta Registr	22	31. Data filad (Month, Dey, Yaar)	CARR, A	strer's Signatura Davidson R		MOSPITAL	OF	VACTIM	OTE

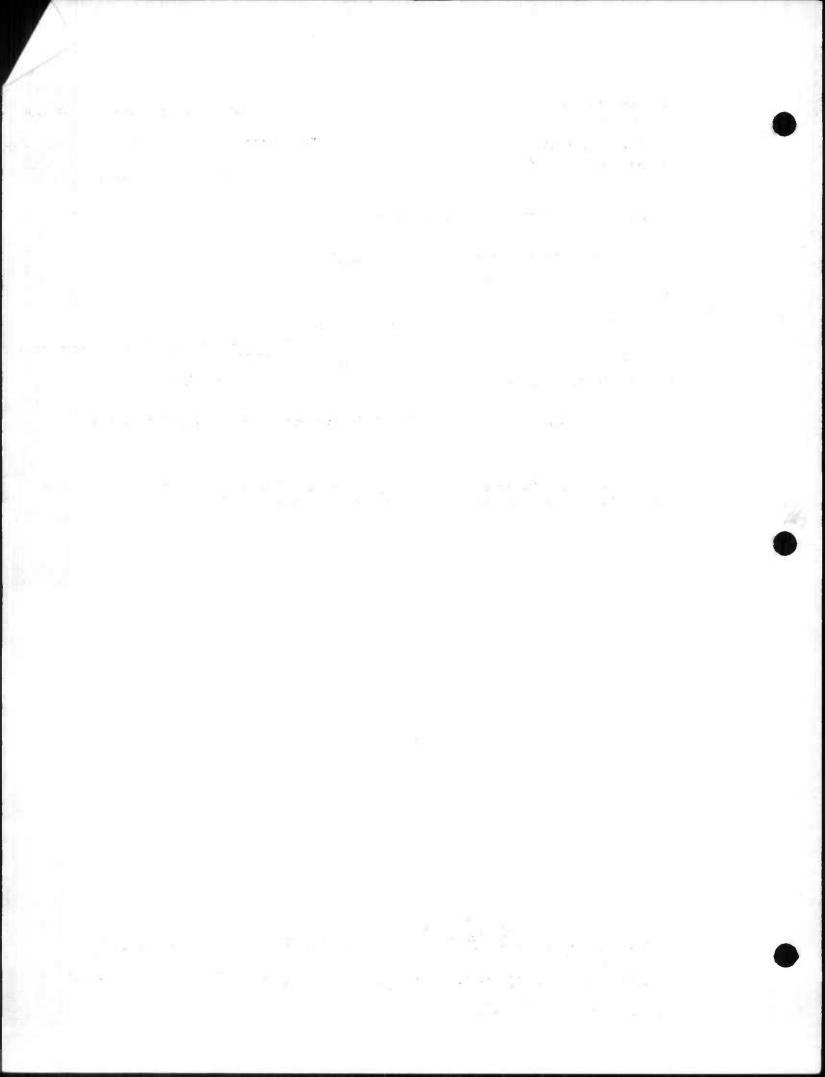


State of Maryland / Department of Health and Mental Hygiene

_						Certificate	of Death	,	Reg. No.	08452	
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Mrs. Kathle	en		Leone		2. Date of De Month	Day Year		
)	Exami		4a. Facility Name (If not institution, giva str	eet end number)			4b. City, Town, or L		4c. County of De	ath	
			Mariner Health Ca	e of Gr	eater La		Laurel		Prince	George	
	Funeral Director		5. Social Security Number 346-24-3016 Usual Residence of Decedent	7. Ag	a (In yrs. lest birth	Months D	aar If Under 24 Hrs. Ays Hours Min.	8. Date of Bir (Month, De Oct. 2	th 9. B by, Year) 9. B 8, 1930 Mic	nthplace (State or Foreign Sountry) Chigan	
	show	-	10a. State 10b. County		10c. City, Town					10d. Insida City Limits	
	M Page	Scto	MD Prince Ge	rge	Belts					1 ☐ Yes 2 ☐ No	
	23a or 2	Funeral Director	10e. Street and Number 10306 45th Place			10f. Zip Cod 2070			10g. Citizen of What C	Country?	
020	n 72 hours ofter death with the Maryland "natural", or frems 23a or 28a-f show after Examinat he notified at	by	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Dacedent I Armed Forcas? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		13. Was Decedent If Yas, specify (of Hispanic Origin? (Sp Cuban, Maxican, Puerto No <i>Specify:</i>	ecify Yes or No Rican, etc.)			
121	within ene. than	Completed	15. Decedent's Educa (Specify only highast grade of Elementary/Secondary (0-12)	ion om <i>pleted)</i> College (1-4or 5	+)	fe. DO NOT use re	ne during most of work	ting	16b. Kind of Busines	s/Industry	
	o filed with al Hygiene. other than		Unavailable 17. Fether's Name (First, Middle, Last)			Cashier	19 Mothada Nam	a /Final Middle	Retail		
5	S to to	Be							Maidan Sumema)		
5	d 2 should b th end Mente 7 is marked traumatic e	To	Arthur Lyman 19a. Informant's Name/Relationship (Type	0.54	1 101 1			Leadbea			
Z :	d 2 strain of train		Al Herman/Son	Printy			eet end Number or Run			Zip Code) , Maryland 2	
	f Heelth ttem 27 i		20a. Method of Disposition				_	Data	20c. Location - City o		
saitimore,	Pages ment of ant: If it ury or o		1 ☐ Burial 2X☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	oval from State		isposition (Neme o cremetory or other ore Washi	ngton Cr	3/19	Laurel, M.	and the same of th	
Ball	Depart Depart Import any in		21. Signature of Funeral Service Licenses	ROD		22. Name and Ad Fleck I	dress of Facility Juneral Hom	e, Inc.			
,00700	rincate be executed ng physician end as the buriel-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last	ı	Due to (or as a con	nsequenca of):				6 years	
POX	e ettending	clan/M	d								
. 1	by the tached	nysic	Part II. Other significant conditions contrit						obacco use contribut	a to the cause of death?	
	96	Dy P	Pleural METASTA.	SES. E	NTEROC	UTANE	OUS FISTUR	/A 10	Yee 2 No 3 I	Probably 4 Unknown	
necouns,	R)	Completed by Physician/M	TOTAL diSTAL GA						en autopsy 24b.	Wera autopsy findings available prior to completion of cause of death?	
	certificate rector, pa	Be Co	IARGE AND SMA 25. Was cese referred to medical	11 bowe	21 065	TRUCTION	26. Place of Deet	1 Y	/ -	1 ☐ Yes 2 X No	
Division of Vital	d is	2	examiner? 1 Yes 2 No Hos 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	oital: 1 ☐ Inpatier 28a. Date of Injun (Month, Dey	nt 2 ER/Outpe (Year) 28b. Tim Inju	e of 28c. In	Other: 4 Nursing Ho	me 5□ Resid	lence 8 Other (Speciow Injury occurred	ecify)	
	rs after deatl al Director: ed in by the	Certification:	3 Suicide 8 Could not be determined	28e. Place of Inju building, etc.	ry - At homa, farm (Specify)	street, fectory, offi	се	28f. Location (S City or Tow	Street and Number or F m, Stete)	rural Route Number,	
Ne Hoen	within 24 hours after To the Funeral Dire completely filled in E	edicai	29e. Certifier (Check only one) 152 Certifying Phyalci 2 Medical Examiner	n: To the best of On the basis of and manner stat	examination end/o	eath occurred at the r Investigation, in m	time, dete and place, y opinion, death occurr	end due to the d ed at the time, d	cause(s) and menner e dete and place, and du	s stated. e to the ceuse(s)	
1	To To E	Σ	29b. Signature and title of certifier		0/		ense number		29d. Data signed (Mon		
			Muyach AT	TENDING	Physica	AN D	16200)	MARCH 16	1997	
	7		30, Name and eddress of person who comp	eted cause of de	ath (kem 23a) (Ty	pe, Print)	(AIDEI)	Longe	/ m Cn	1,1997 ZIZZB	
	Star Registra		31. Date filed (Month, Pay, Year)	32 800 days	Spandall				art y Cor	11/0/	



			State of Maryl		rtment of l tificate of			giene Reg. No.	7 08453
	Physici /Medi		Decedent's Name (First, Middle, Last) Thomas F. Lemmey				2. Data of De Month Februar	ath Day	3. Tima of Death 7:09 pm
	Examir		4a. Facility Name (If not Institution, giva street end number) 1931 St. Paul Street			4b. City, Town, or I	ocation of Death		
Ī	Funeral Director			yrs. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birt (Month, Da 2/24/2		Birthplaca (Steta or Foreign Country) ew York
	pue *		Usuai Rasidence of Decedent 10a. Stata 10b. County 10c	c. City, Town or Loc	eation				10d. Inside City Limits
	Manyli 4 sho	20	Maryland	/Baltimo					12 Yes 2 No
	r 28a	rec	10e. Street and Number		10f. Zip Code			10g. Citizan of Wh	at Country?
	th wit	alD	1931 St. Paul Street, Apartm	ient 4	21218	3		US	A
020	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 12. Was Decedant Ever Armed Forcas? 1 Never Married 2 Married 3 □ Widowed 4 □ Divorcad 12. Was Decedant Ever Armed Forcas? 1 Never Married 2 Married 1 Never Married 2 No If Yes, Give Year or Datas:	If	/as Decedent of F Yas, specify Cub ☐ Yes 2 No	lispanic Orlgin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, atc.)	14. Race - Biack, Specify:	American Indian, White, etc.
2-0	72 hora	pete	15. Decedent's Education (Specify only highest grede completed)	16e. Decede	ent's Usuel Occup	pation during most of word)	tina	16b. Kind of Busi	ness/Industry
21215-0020	within ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	lifa. D	O NOT use retire	during most or wor	el V	Mass Tra	nsit Associatio
Maryland 2	and Mental Hygiene. Is marked other than summitic event, the Mental	To Be Co	17. Father's Name (First, Middle, Last) Robert Lindsay Lemmey	0.00	car vy /			Maiden Sumema) h Sleate	
lary	2 shot and N is mar		19a. Informant's Name/Relationship (Type, Print)			and Number or Ru			
	is 1 and 2 if Health if Hem 27 li other tra		David Luck nephew			e Drive,			13440-7336
Baltimore,	permit. Pages i Department of F Important: if its eny injury or of once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 ☐ Other (Specify)		etory or other ple	1	Date	20c. Location - Ci	
Bal	Depar Impor eny in		21. Signal and Funeral Service Licensee 10. Wade, Director			ess of Facility Itomy Boa e, Maryla:			more Street
			Pert1. Enter the disease, or complications that caused the caused, or heart failure. List only one cause on each line.	death. Do not enta	r the mode of dyle	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		immediete Cause (Final disease or condition resulting in death)	real	clore	اسا	·		3 Mo
L	P #	Iner	Squar	to (or as a consequ	lence of):	CA -	Lung		3 m
ć	cate be axecuted physician and the burial-transit	Examiner	if any, leading to Immediata	to (or as a consequ	ienca of):		1		
58760,	cate be ohysicie the bu	dical	cause. Enter Undertying Cause (Disease or injury that hitiated events resulting in death) Last C. Dua to	to (or as a consequ	ence of):				
Box 6	the death certific y the attending p	Physician/Me	d						
	death	sicla	Part ff. Other significant conditions contributing to death but not	resulting In the un	dertying cause giv	ven in Pert f.	23b. Dld 1	obacco use contr	ibute to the cause of death?
s, P.O	as that the de igned by the a be detached	by Phy	COSD				16.	Yes 2□No 3	☐ Probably 4☐ Unknown
Record	aw requir	Completed						an autopsy med?	24b. Were autopsy findings available prior to completion of causa of death?
E E	The sta h	Com					101	as 20 No	1 Yes 2 No
Vital	Physicien: The this certificata ral director, page	o Be	25. Was case referred to medical examiner? Hospital:		ou pos Ott	26. Place of Des			
of		-	27. Manner of Death 28a. Date of Injury	2 ER/Outpatient 28b. Time of	3□ DOA 28c. Injui	4 LI Nursing H		lence 6 Other	
ion	Attending For death.	atlor	Natural 5 Pending (Month, Dey Year	nr) Injury		rk? Yas 2 □ No			
Division	7 7 7 6	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp	At home, farm, stree	et, factory, office		28f. Location (S City or Tox		or Rural Route Number,
1	To the Hospital or within 24 hours after To the Funeral Director Completaly filled in	edical	29e. Certifier (Check only one) Certifying Physician: To the basis of examiner: On the basis of exam and manner stalled.	knowledge, deeth onination and/or inve	occurred et the tie estigation, in my o	me, date end piece ppinion, death occu	, end due to the orred at the tima,	ceuse(s) end mann date and piaca, and	er as stated. d due to the cause(s)
A	To the To the compl	Me	29b. Signature and titla of certifier	MI	29c. Licans	se number		29d. Date signed (Month, Dey, Year)
			Hegy 1 1 cfe		1)25	1662		3/7/	97
			30. Name and address of person who completed cause of death (Item 23a) (Type, P	3 N. C	slow	St-R	-540 /	2/2/8
	Sta Registr		31. Data filed (Month, Day, Year) 32. Registrars Si	ignatura ignolette					



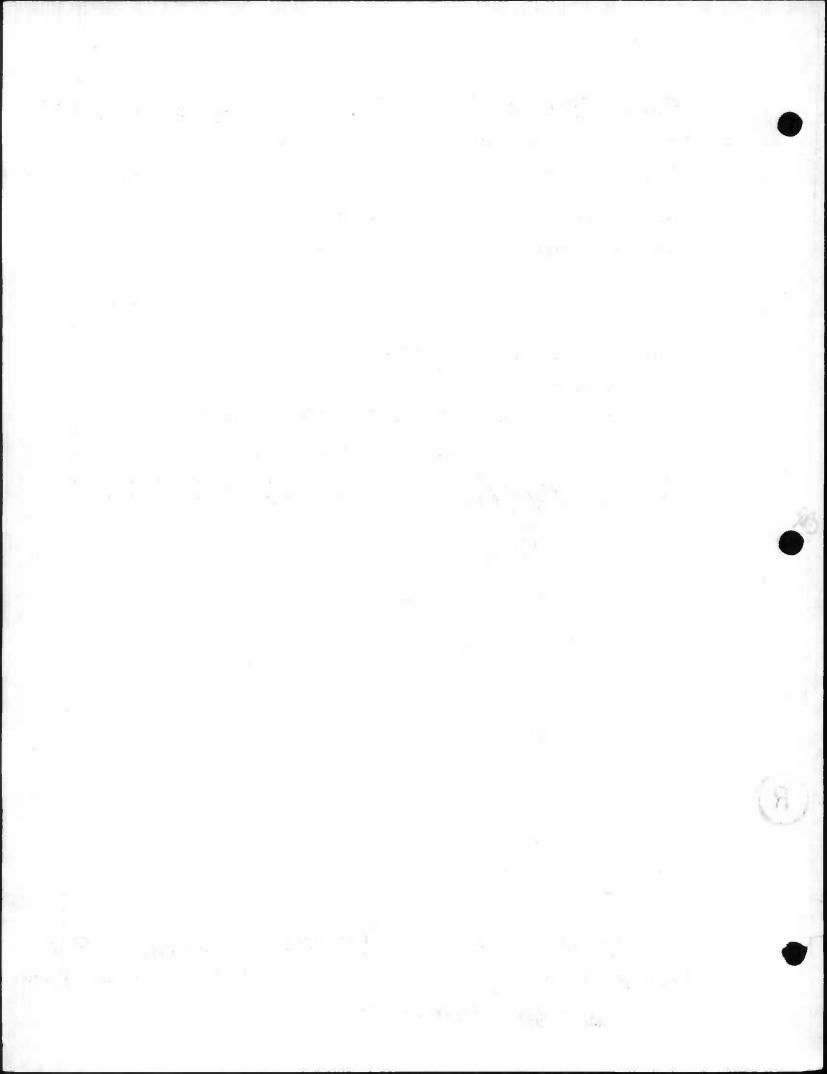
State of Maryland / Department of Health and Mental Hygiene Item18 3-25-97 FilmG745 W.H.Per F/H 08454 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tim f th **Physician** Day Stephen Lowery 6:30 144 MARCH 17 /Medicai 4a. Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Daath Examiner frankford Baltimore aty orien Baltimore If Under 1 Year if Undar 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 8. Data of Birth (Month, Day, Year) 08-17-67 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country)
 DC **Funeral** Months Days 1 M 2 □ F 218-84-2632 Director 29 Yrs. Usual Rasidance of Decedant the Maryland 10a State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits MD NA Baltimore Director tX Yas 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1310 E. Belvedere Avenue 21239 USA "natural", or items 23a death Funerai 12. Wes Dacedant Ever in U,S. Armed Forcas? 13. Wes Dacedant of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian Black, Whita, atc 72 hours after Navar Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0020 1 Yas XIX No Spacify: Specify: Black by 3 Widowed 4 Divorced Yaar or Dates: Completed traumatic event, the Medical 16a. Decedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. mentary/Secondary (0-12) Collage (1-4or 5+) 12th Grade Management Grocery Store other permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Ilem 27 is merked othe any Injury or other traumests 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Vernice Thomas Μ. Lowery Rufus 19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, Steta, Zlp Coda) 21202 19a. Informant's Name/Ralationship (Type, Print) Russell Lowery 221 E. Preston Street Apt. 2R Balto., Md. 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 Burial 2 Crametion 3 Ramoval from Stata Voshell Mem. Gardens 03-20-97 Dundalk, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signetura of Funda Sarvice Licensee 22. Nama and Addrass of Facility Baltimore, Maryland WM.C.March FH 1101 E. North Avenue 21202 mes Pert1. Entarthe diseesa, or complications and caused the death. Do not anter the mode of dying, such es cerdiac or respiratory arrest, shock, or neart fallure. List only one couse on each line. **Physician** /Medical Immediate Cause (Finel disaasa or condition resulting in daath) Septic Shock 48 hrs Examiner Dua to (or as a consequence of): AIDS wowan that the death certificate be executed Sequantially list conditions, if any, laading to immadiata ceusa. Enter Underlying Causa (Disaasa or Injury that initiated evants resulting in daath) Last and Dua to (or as a consequence of): Box 68760, physician Physician/Medical the Dua to (or as a consequence of): 98 for use es P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. the 23b. Did tobacco use contribute to the cause of death? 2 1 Yee 2 No 3 Probably 4 Unknown signed b Records, þ 24b. Wera autopsy findings evailable prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? Deed page 2 1 Yas certificate 1 Yas 2 No Vision of Vital 25. Wes cesa refarrad to medical Be 26. Piece of Death (Check only ona) exeminar? Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 this 27. Menne of Deeth 28b. Time of Injury Certification: 28d. Dascribe how Injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury et Work? 1 Netural 5 Pending investigation 1 Yas 2 No 2 Accident 6 Could not be 3 ☐ Suicida 28a. Place of Injury - At homa, farm, street, fectory, office building, atc. (Spacify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stata) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the tima, data and place, and due to the ceusa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and mannar steted. 29a, Cartifiai To the Hope within 24 hos To the Functional Completely Medical 29b. Signetura and title of certifiar 29c. License number 29d. Dete signed (Month, Day, Year) Thomas Whuss 30. Nama and eddrass of person who completed ceusa of death (Item 23e) (Type, Print) S, RUSSI thickory Pidge Pd 10805 2 Registrar's Signatus Rendells State Registrar

Zie r y sammer

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Decedent's Name (First, Middle, Las	it)		Certificate o	Death	2. Dete of De	Reg. No.	97	. Time of Deet
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2 2	ral Director	10e. Street end Number 528 S. Curley St	reet		10f. Zip Code 21	224		10g. Citizen of USA	Whet Country?	
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	Exami		4a. Fecility Name (If not instituti					4b. City, Town, or L			of Deeth	
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	Funeral Director		5. Social Security Number 218-22-0555 Usual Residence of Decedent	6. Sex 1 ☑ M 2 ☐ I			Under 1 Year lonths Deys	If Under 24 Hrs. Hours Min.	(Month, De	rth ey, <i>Year)</i> RY 3,190	9. Birthplac Country 9 MAI	ce (State or Foreign y) RYLAND
	ahow		10a. State 10b. Count	у	10c. C	ity, Town or Locat	on				100	f. Inside City Limits
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	or 28a-f	rec	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Country	13
	23a c	a D	715 MAIDEN CHO	ICE LANE	- CC-61	0	21	228		11.5	S.A.	
	within 72 hours after death with the Maryland ens. than "natural", or items 23s or 28s-f show he Medical Examiner must be notified at	by Funeral Director	11. Meritel Status 1 Never Merried 2 Ma 3 Widowed 4 Divorce	12. Wes D Armed 1 1 Ye if Yes,	Pecedent Ever In I Forces? es 2 X No	U,S. 13. Was		dispanic Origin? (Si en, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		ce - American	C.
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	of Health item 27		20a. Mathod of Disposition		-	Place of Dispositio	on (Name of		Date	20c. Location		
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	ne death the atte	sici	Part II. Other significant condit	ons contributing to	death but not re	suiting in the unde	rlyIng cause giv	ren in Part I.	23b. Dld	tobacco use co	ntribute to ti	he cause of death?
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-	tal or Attents after deal	Certific	3 Suicide 6 Coulc 4 Homicide	nined 200. Pil	aca of Injury - At I ilding, etc. (Spec	nome, farm, street, ify)	fectory, offica		26f. Location (City or To	Street end Numl wn, State)	ber or Rural F	łoute Number,
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	Medical	29a. Cartifler 1 Certifyl (Check only one)	Examiner: On the	the best of my kn basis of examin anner stated.	owledga, death oc ation and/or invest	curred at the tir igation, in my o	ne, date and placa, plnion, death occur	and due to tha red at the time,	causa(s) and madate end piaca,	anner as stat and due to th	ed. ne cause(s)
	To the Compl	Me	29b. Signature and title of certification				29c. Licens	e number	T	29d. Date signe	d (Month, Da	ıy, Year)
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	10		30. Name and addrass of person	who complated co	ause of death (Ite	m 23a) (Type, Prin	it)	105) lane, ca		. ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1-1-	
			Andres Sala		711 M	gidenc	hoice	lane, ca	tonsvi,	11e, M.	0,2	1228
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** SALLY LESSANS 11:10 AM 97 MARCH 16 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 6. Date of Birth (Month, Dey, Yeer) 5 Social Security Number 7. Age (In yrs. last birthdey) Funeral Deys 1□M 2X F Director 215-22-3822 NOV. 19, 1914 Usual Residence of Decedent the Maryland 10e Stete 10h. County 10c. City. Town or Location 10d. fnside City Limits 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Director MD BALTIMORE BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ò 238 16 OLD COURT ROAD #716 21208 U.S.A. Funeral Herns 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Yes ZXNo 1 Never Married 2 Married Maryland 21215-0020 ò 1 ☐ Yes 3 No Specify: Specify: WHITE þ Sta Widowed 4 □ Divorced Year or Dates 'natural', Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiane. Eiementery/Secondery (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othe any Injury or other traumatic event appea. 18. Mother's Neme (First, Middle, Maiden Sumeme) Be SAMUEL SCHLOSSBERG REBECCA FRIEDMAN 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) BARBARA SCHAFTEL / DAUGHTER 301 OLD CROSSING DRIVE BALTIMORE, MD 21208 Baltimore, Pleca of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 X Burial 2 Cremation 3 DRemoval from State 5 Other (Spe 4 Donal ORBAND 3/17/97 ROSEDALE, MD eral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 Reisterstown Road Pikesville, MD 21208 plication, that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, one cause on each line. Approximete Interval Betwe Onset end Deeth Physician /Medical Immediate Ceuse (Final · ARTERIOSCLEROTIC CARDIOVASCULAR YEARS disease or condition resulting in deeth) Examiner DISEASE Due to (or es a consequenca of): Physician/Medical Examiner physician and s the burial-transit ires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): Box 68760. Due to (or es e consequença of) P.O. Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown signed t STENOSIS AORTIC Records, 2 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Vital Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No of 28a. Dete of Injury (Month, Dey Year) 27. Menger of Deeth 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? Division Attending 1 Naturel 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Sulcide 6 Could not be determined 28e. Plece of fnjury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) or A aftar 4 Homleide To the Hospital within 24 hours a To the Funeral Complately filled Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner stated. 29a, Certifier Medical (Check only one) 29b. Signeture end title of cartifier 29c. License number 29d. Dete signed (Month, Dey, Year) 043462 K.S. RAO. MI.D MIARCH 16

State Registrar

32. Registrer's Signeture

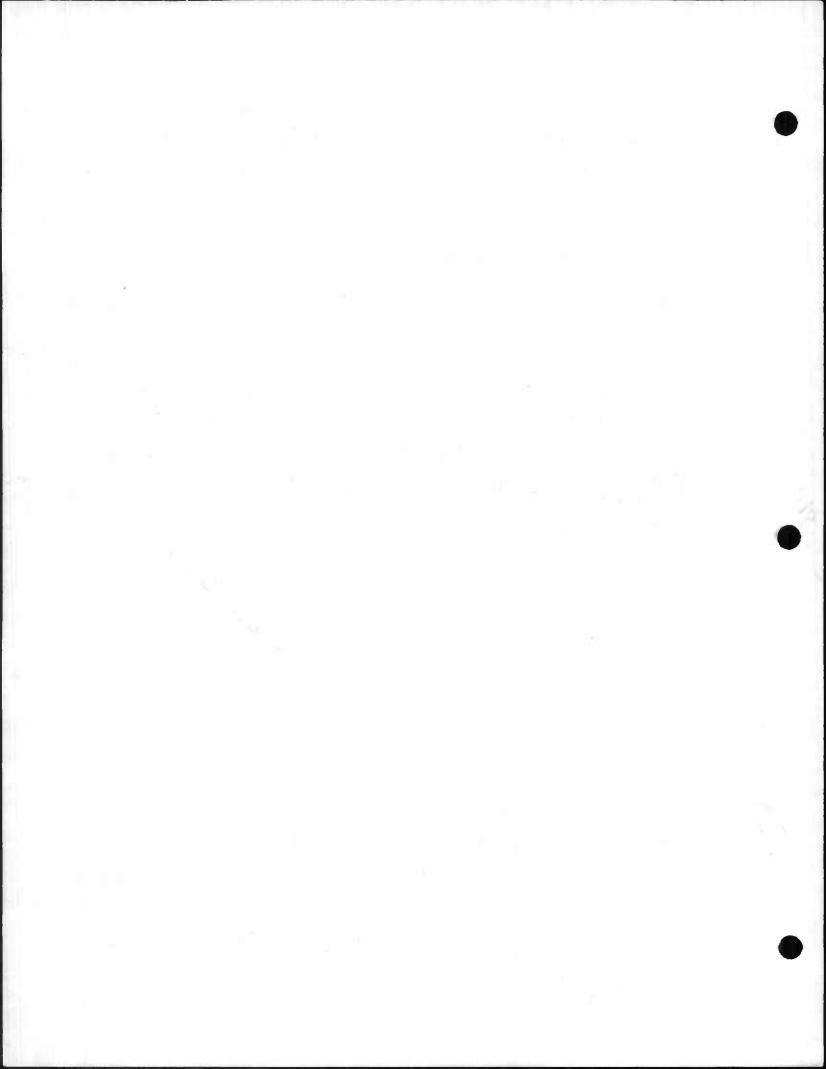
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

HOSPITAL CENTER, RANDALLSTOWN. MD.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** (1/15 Uye 3-56 1997 /Medical lach 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltino re if Undar 24 Hrs. Hospital 6.5 Baltmore 5. Social Security Number if Undar 1 Year 7. Aga (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foraign Country) **Funeral** 10 M 2 F Days 241-64-2815 Yrs. Qug. 22,1 **Director** Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner rount be notified at 1 ☐ Yes 2 PNo Director timore lurners 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Avondale USA 60 21333 Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedant of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status 14. Rece - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Dates: Widowed 4 □ Divorced Black "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Eiementary/Secondary (0-12) Coilege (1-4or 5+) 123 Sweetheart Cup Co line 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be.
Department of Health and Mental I.
Important: If Item 27 is marked off Be should be ind Mental I illiam Arrina Tatsu 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Chestnut St. M. Mills 238 SON Dowingtown, Pa. 19335 erek 20b. Pieca of Disposition (Nema of cemetery, cremetory or other plece) 20e. Method of Disposition Data 20c. Location - City or Town, State Burial 2 Cremation 3 Ramoval from State Allen Grove Cemetery 3-22-91 HALLAX, N.C 4 Donation 5 DOther (Specify) Princure of Funeral Service Licensaa 22. Name and Address of Facility Sons Ė James 54. Balto, MD alla 1701 21217 aurens 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heer feilure. List only one cause on each line. Approximate interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) Open to the state of the state /Medicai Examiner Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Diseasa or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by t d be datach 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy performed? cartificata has b inector, paga 2 sl Yes 2□No Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 es 2 No Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Naturai 5 Pending Investigation injury =00 PM 1 Yes 2 No 2 Accidant 14 1997 (cuetagn Street 4 3 Suicide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Retite Number, City or Town, Stete) 4 Homicide Dire a te Painters Mill + Respitoin street To the Hospital within 24 hours a To the Funeral D complataly filled in 1 Certifying Physician: To the best of my knowledge, daath occurred at the time, date and piace, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edicai 29a. Certifier 29b. Signatura and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year) #N8249 Johns blopins 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 luch la resident 1 By/homes 17) Timothy Evenet Hellow 31. Date filed (Month, Day Year)
WAR 19 1997. Hospital State Registrar



ITEM#1,10b,18 PER PHYS. FLM#G745 3/24/97 J.A.

07 001 00

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR	TMENT OF	HEALTH AND F DEATH	MENTAL HYGIEN		0045
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	MY YEA	3. TIME OF DEATH
			MERRITT			3-5-	97	8 35 TIME OF DEATH
١,	4. SOCIAL SECURITY NUMBER		yrs. lest birthday)	IF UNDER 1 YEA		7. DATE OF BIRTH (Month, Day, Ybar)	8. Bi	RTHPLACE (State or Forei
1	301-36-6022	1 🗆 M 2 🗹 F	92 YRS.			6-20-		cottland
5	Brightwood center		er Care		n or location of the shifteed for	ed, Luthervill	9c. COUNTY O	imore
딥	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	v	70.00	Y, TOWN OR LO				Lead marks are
L DIRECTOR	m) 120	07 BOXOT Hill	-Road	Baltin	ore Hunt	Valley		10d. INSIDE CITY LIMITS? 1 YES 2 X NO
FUNERAL	12007 Boxer Hil				21030		U.S.	A.
BY FU	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Biversed	12. WAS DECEDENT EVER IN I FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 NO	II yes,		ANIC ORIGIN? (Specify Yes, an, Puerto Rican, etc.)	В	ACE — American Indian, Hack, White, etc. pacify: White
מ	15. DECEDENT'S EDU	CATION	Ida. DECEDENT'S	USUAL OCCUPA	TION	16b. KIND OF BU	SINESS/INOUSTR	γ
ᄪ	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT us	work done during se retired.)	most of working	Heal	t h	
COMPLET	12	2	Nurs	e				
8	17. FATHER'S NAME (First, Middle, Last)					AME (First, Middle, Maider		
BE	Andrew Banks He	ron				n Currie SM		
2	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Stre	et end Number or Rural	Hunt Val	State, Zip Code)	
	Mary J. Brady		1200	7/Boxer	Hill Roa	ad, Baltim o	re, MD	21030
	20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Rem		LACE AND DATE O	OF DISPOSITION			OCATION — City or	
	4 Donation 5 Other (Specify)							
	21. SIGNATURE OF FUNERAL SERVICE LICE JOSEPH B		_	22. NAME Sta	AND ADDRESS OF E	ny Board, 6	555 W. B	altimore S
	Court B. G	m/ San/						land 21201
	IMMEDIATE CAUSE (Final disease or condition resulting in desth)	a. DUE TO (OR AS A C	(O.V.	<u>(</u>	CAN	ICET		Onset and D
NO.	Sequentially list conditions, if any, leading to immediate	b DUE TO JOR AS A C	ONSEQUENCE OF		-			
3	cause. Enter UNDERLYING CAUSE (Disease or Injury	c.			ů			
E	that initiated events	DUE TO JOR AS A C	ONSEQUENÇE OF	ŋ:				
CERTIFICATION	resulting in death) LAST	d	4					`
AL C	PART II. Other significent condition	s contributing to deeth but	not resulting i	n the underly	ing cause given in	Part I. 24s. WAS AN	AUTOPSY	24b. WERE AUTOPSY FIND
MEDICA			-			PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAL
						1 _ YES :	Z 🗆 NO	OF DEATH?
2	DID TOBACCO USE CONT	RIBUTE TO CAUSE OF	DEATH YE	S D NO	☐ UNCERTAI	IN []		1 YES 2 NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEAT					
	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outpet	ent 3 DOA	OTHER:	ome 5 🗆 Residence	& Coher (Specific)		
PHY	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIMI	E OF 28c.	NJURY AT	28d. DESCRIBE HOW	NJURY OCCURED	
BY P	1 Natural 5 Pending	(Month, Day, Year)	INJ		WORK? YES 2 NO			
	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — building, etc. (Specify	At home, ferm, s	treet, factory, of	fice	281. LOCATION (Street City or Yown, Stelle)		el Route Number,
COMPLET		CIAN: To the best of my knowled						
8		R: On the basis of examination s	mazor investigation	n, in my opinion	, death occured at the	e time, date and piece, er	nd due to the ceus	e(e) end manner es state
H H	296. SIGNATURE AND RITLE OF CENTIFIES	0028.0	00		299 LICENSE NU	POS S	29d. DATE SIGN	ED (Month, Day fear)
임	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DEAT	H (ITEM 27) /June	Print)	1 420	100	1 2/	(0/4)
	Sheller M.C	ABBAIL 40	m) (500	1 ADa	200 RAL	4100	L /10 2
	31. DATE FILED (Modith, Day, Year)	932, REGISTRAR'S CICHAT	URE UNE	10		THU WHIT	111118	14114

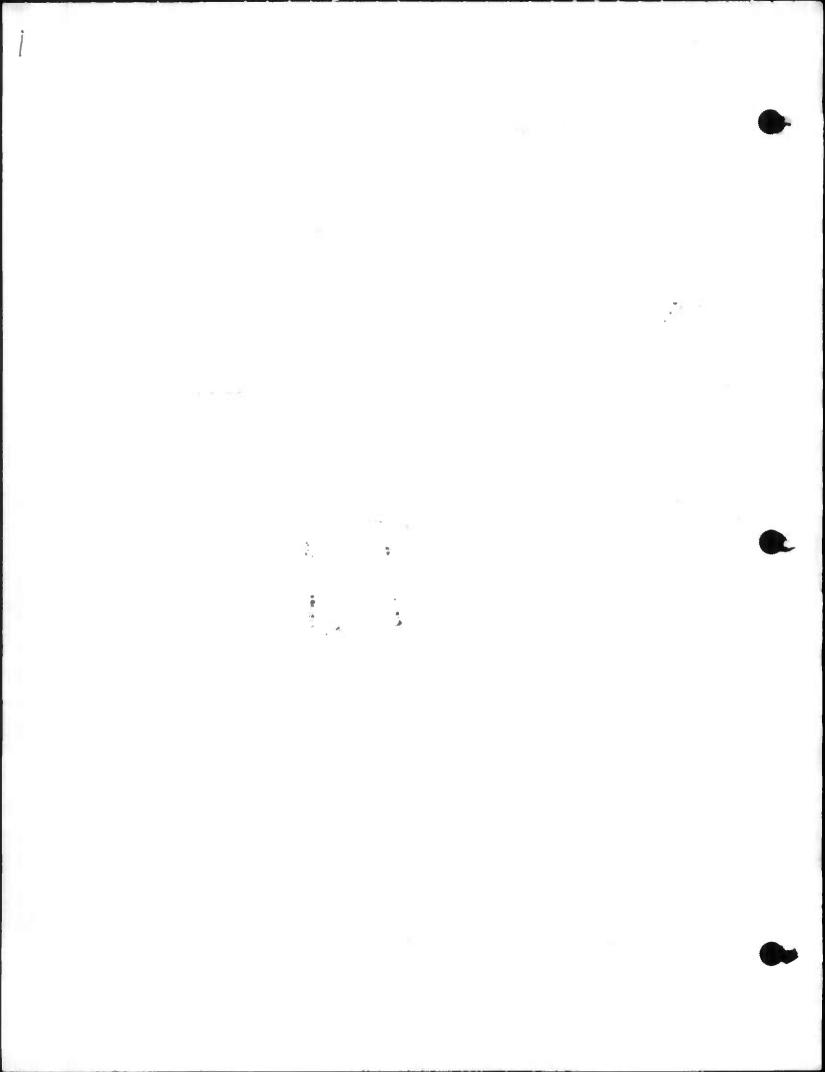
DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

31. DATE FILED (Modifit, Day, Year)
MAR 1 9 1997

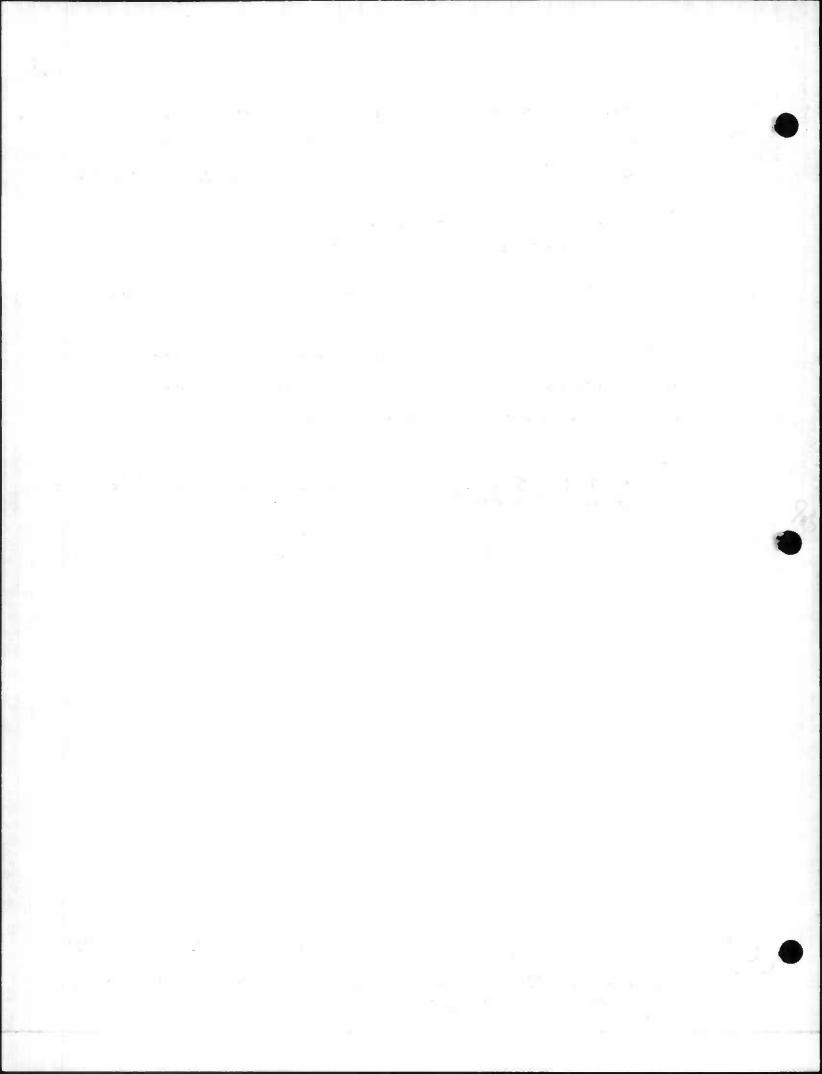
whe Davidson

fandelle



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

£			Decedent's Neme (First, Middle, Last,)	Ce	rtificate of	Death	2. Dete of D	Reg. No.	21	08460
	Physic		ROBERT	AUSTIN	MTE	ewen.		Month	Dey	Yeer	
	/Medi Examir		4e. Fecility Neme (If not institution, give	street end number)	MIE		4b. City, Town, o	MARCH or Location of Dec		1997 County of Deeth	0115 a.m.
	LAGIIII	161	Sacred Heart Hos				Cumber			llegany	
	Funeral		5. Social Security Number 6. Sec	7. Age (In)	rrs. lest birthday)	If Under 1 Year	If Under 24 H	s. 8. Dete of E			plece (Stete or Foreign
u.	Director		375-09-6187 Usuel Residence of Decedent	M 2□ F 75	Yrs.	Months Deys	Hours Mi	5/13/		Mich	
	show	2	10a. State 10b. County N/MD	10c.	City, Town or Lo					1	10d. Inside City Limits 12€ Yes 2 □ No
	r 28a-f	recto	10e. Street end Number		Cumberl	10f. Zip Code			10g. Citize	en of Whet Cour	
	23a o	Funeral Director	14611 N. Bel Air			2150			US		
020	filed within 72 hours after death with the Maryland Hydione. ther than "natural", or items 23s or 28s-f show int, the Medical Examiner must be nested at	by	11. Maritel Stetus 1 □ Never Merried 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 □ No If Yes, Give Yeer or Dates:		Wes Decedent of Information of Info		(Specify Yes or Nerto Ricen, etc.)		4. Race - Americ Bleck, White, Specify: Wh	etc.
21215-0020	filed within 72 ho Hygiene. ther than "natur int, Ins Medical	Completed	15. Decedent's Edu (Specify only highest gredi Elementery/Secondery (0-12) 12	cetion e completed) College (1-4or 5+)	(Give	dent's Usuel Occup kind of work done DO NOT use retire	during most of w d)	orking		of Business/In	dustry
0	tal Hygi d other event, I		17. Fether's Neme (First, Middle, Last)	4	Citemi	cal Engi		ame (First, Midd			
ylan	o a b	To Be	Frank Adam Miesme	er				Harriet			
Maryland	d 2 sh th end 7 is m traum		19a. Informent's Name/Reletionship (Ty Marjorie Miesmer			ng Address (Street			ber, City or	Town, Stete, Zip	Code)
co .	E E		20a. Method of Disposition 1 Buriel 2 Cremetion 3 R 4 Donetion 5 Other (Specify)	20	o. Piece of Dispo			Dete		ation - City or To	own, State
Balti	permit. Pages Department of I- Important: If ite any injury or of once.		21. Signature of Fiberal Service License Ronald S. Wade	Director	22	Name end Addre State An Baltimor	atomy Bo			Baltimo	re Street
*	Physician /Medical Examiner		Part 1. Enter the disease, or complishook, or heart feilure. List only or Immediate Ceuse (Finei disease or condition resulting in death)	cetions thet ceused the decause on each line.	nta	er the mode of dyle	af A	ec or respiretory	errest,	al .	Approximete Intervel Between Onset end Deeth
	outed brankli	Examiner	Sequentially list conditions),	o (or es e consec	derive oi).			(
68/60,	ncate be executed the physician and is the burial-trans	edicai Ex	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest). ————————————————————————————————————	(or as e conseq	•				[[
×	nding use au	_	resulting in death) Lest	1		_				to the star of the	
	by the atter	Physician/N	Pert II. Other significent conditions con	kibuting to death but not	resulting in the u	nderlying ceuse giv	ven in Pert I.	23b. Die	i tobacco us	se contribute to	o the cause of death?
1	signed by d be detac	by Phy	Prttriose	Drolie (arde	09000	lor Q	west 10	Yes 2⊠	No 3□ Pro	bably 4 ☐ Unknown
Vital Records,	sw requisite particular support	Completed						24e. We	s en eutopsy formed?	ev co	ere eutopsy findings elieble prior to impletion of ceuse deeth?
E H								1□	Yes 2	No 1 [☐ Yes 2☐ No
5	certificate rector, pay	Be	25. Wes cese referred to medicel examiner?	lospitei:		Oth	or.	eeth (Check only			
	nding Priya ith. 7 After Ihis o 6 funersi dir	Ion: To	27. Manner of Deeth 1 Naturel 5 Pending	28e. Dete of Injury (Month, Day Year	ER/Outpatien 28b. Time of Injury	28c. Injui	y et rk?	Home 5 Re-			(y)
NIS.	ther dead linector: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Plece of Injury - A building, etc. (Spe	t home, farm, str		Yes 2 □ No		(Street end a own, Stete)	Number or Rura	al Route Number,
	Funeral E	edical Co	(Check only 2 Medical Examin	ilcian: To the best of my liner: On the basis of exam	nowledge, death	occurred et the tir	me, date end place	ce, end due to the	e ceuse(s) e	nd menner as s	feted. the ceuse(s)
1	d die	Med	29b. Signeture end title of pertifier	end menner steted.		29c. Licens				signed (Month,	
C	F)		Mo/4	actor		D 11	44.3		March		1997
/	ン		30. Neme end eddress of person who so	mpleted ceuse of deeth (i	tem 23e) (Type,	Print)	ve Cu	naherla	nd I		
	Sta	ite	31. Dete filed (Month, Dey, Year)	32Mediatrer's S	pature 00	n Ull	re Cu	MOCH	crity /	.0 01	20 20 1



Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelith and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exerciper must be notified at once.

Physician /Medicai **Examiner**

To the Hospital Argumenting Physician: The lew requires that the death certificate be executed within 24 hôurs effect death.

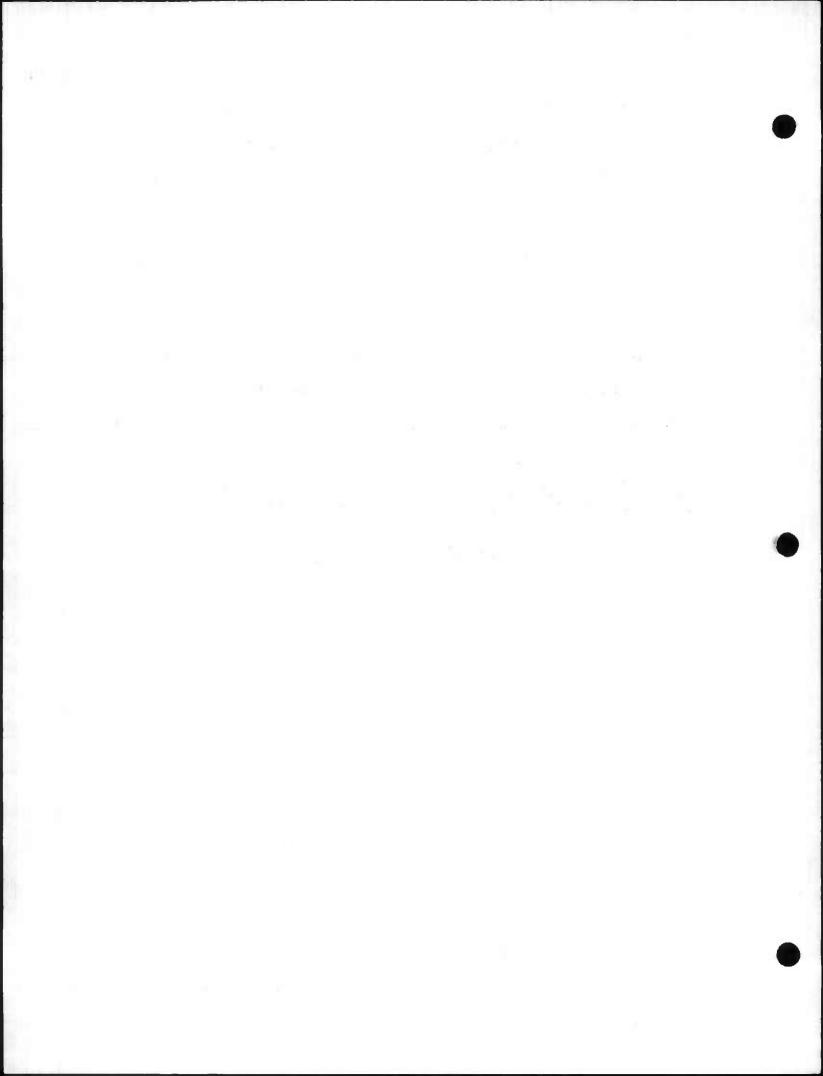
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit

on of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	Decedent's Neme (First, Middle, Last)		Certificate of		2. Dete of D	rieg. Ivo.	97 0846 3. Time of De
an	BRIAN MARK	McBRID	F		Month	Dey	Yeer
cal	4e. Fecility Neme (If not institution, give street end			4h City Town (MARCH or Location of Dee		1997 11:047 by of Deeth
ner							
	5701 BALTIMORE NATI 5. Social Security Number 6. Sex	7. Age (In yrs. last bi		CATONS If Under 24 H	SVILLE	BALT	
	214-64-6223 1XM 201		Yrs. Months Deys	Hours M	in. (Month, D	ey, Yeer)	Birthplece (Stete or F Country)
	Usuel Residence of Decedent	50			June 2	, 1966	Maryland
	10a. Stete 10b. County	10c. City, Tov	wn or Location				10d. Inside City I
P	Maryland Baltimore	D	ol+dmone				1 ☐ Yes 2
Director	10e. Street end Number	D	altimore 10f. Zip Code			10a Citizen of	Whet Country?
ā	5701 Poltrimone Notice	-1 D.U				7.00	
To Be Completed by Funeral Director	5701 Baltimore Nation	AL PIKE Decedent Ever in U.S.	21228		(Specify Ves or N	U.S.	. A .
5	Armed	d Forces?	If Yes, specify Cub	en, Mexican, Pu	erto Rican, etc.)		eck, White, etc.
by F	If Yes,	es 2 🔀 No , Give or Dates:	1□ Yes 2덨 No	Specify:		Speci	y: white
	15. Decedent's Education		a. Decedent's Usuel Occup	etlon		16h Vlad -/ *	Quelpace/laduata
Completed	(Specify only highest grade complete	ed)	(Give kind of work done life. DO NOT use retire	during most of v	vorking	100. Ning of E	Business/Industry
E S		ge (1-4or 5+)	Construction			D., J 1	14400
Ö	17. Fether's Neme (First, Middle, Lest)	0	Jonstiuct10		T leme (First, Middle		lding
Be	Richard Timothy Mc Bri	do					
2	19e. Informent's Neme/Reletionship (Type, Print)		h Mailine Address (Ot.		dette Mc		Chile To Code
			b. Mailing Address (Street				
	Richard Timothy Mc Brid		218 McAdoo A of Disposition (Name of	venue,			21207
	1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel fro	om State cemete	ory, cremetory or other ple	ce)	Dete	20c. Location	- City or Town, State
	4 □Donetion 5 □ Other (Specify) in-s	tate			1		
	21. Signefure of Funerel Service Licensee Joseph B., Van S.	dnt 4 =	22. Neme end Addre		and CEF	TT TO 1.	
	Brad Dille		Baltimore				timore Street
	23a. Part. Enter the diseese, or complications the shock, or heert feilure. List only one cause of	et caused the deeth. Do	not enter the mode of dvi	no. such es card	liac or respiretory	errest.	Approximate
	resulting in deeth)	Due to (or es e	consequence of):	-			
Examiner	Sequentially list conditions, if any, leading to Immediate		consequence of):	~			
cai Examiner	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury	Due to (or es e	consequence of):	}			
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Physician/Medical	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulfing in death) Lesf	Due to (or es e	consequence of):	ren in Pert I.		tobacco use co	1/
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by Physician/Medical	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulfing in death) Lesf	Due to (or es e	consequence of):	ren in Pert I.	1 □		3 Probably 4 Un 24b. Were eutopsy find eveileble prior to completion of caus
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** Month Gladus E. Miller 1997 12:10 AM March /Medical 4a. Fecility Name (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meridian Franklin Woods Nursing Home Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplece (State or Foreign Country)
New York 7. Age (In yrs. last birthday) Funeral Months Days Hours 1□ M 2□XF 78 078-10-0623 **Director** Usuel Residence of Decadent with the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show solical Examiner nunt be notified at 1 Yes 2 No Director Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8620 Kelso Drive 21221 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. filed within 72 hours efter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: White þ Specify: shours to mental Hygiene.
Is marked other than "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Teacher Aide Baltimore Public Sch. 12th grade traumatic event. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) . Peges 1 and 2 should be fill ment of Health end Mental Heart: If item 27 is marked oth jury or other traumatic even Be William Smith Ella Moore 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 115 A Versailles Circle, Towson, MD Mrs. Joan Sarkin (daughter) 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Pege Department of Important: If eny Injury or Green Mount Crematory 3/14/97 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Schimunek Funeral Homes, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final ear disease or condition resulting In death) **Examiner** Examiner oronour buriel-transit The law requires that the deeth certificete be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest and Due to (or as e consequenca of) physician s the burie Records, P.O. Box 68760. Physician/Medical Due to (or es a consequence of) 88 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown abetes 24b. Were eutopsy findings evailable prior to page 2 should Completed 24a. Wes en eutopsy completion of cause of death? 2 DIN 1 Yes 1 ☐ Yes 2 ☐ No æ Be 25. Was case referred to medical 28. Place of Deeth (Check only one) 30 NO Hospital: 1 ☐ InpatIent 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes Menner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No in by the 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 ☐ Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and menner es steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner steted.

29c. License number

29d. Dete signed (Month, Dev. Year)

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within 24 hours a To the Funeral C completely filled Hospital e t

> State Registrar

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29a. Certifier

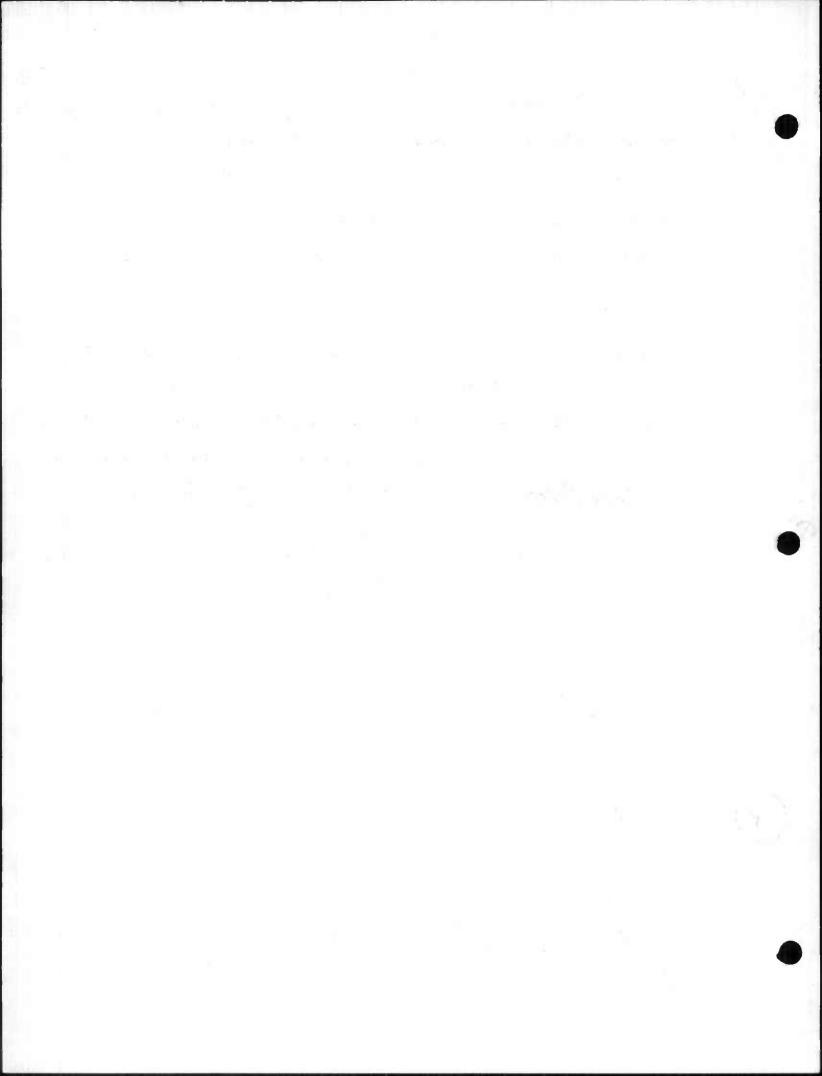
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29b. Signature and

31. Date filed (Month Day Year)

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nd address of person who completed cause of de



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State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Month Joseph McEvou March 1997 4:35 pm /Medical 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Towson if Under 24 Hr Hours Mir Baltimore County If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dev. Year) Birthpiace (State or Foreign Country) **Funeral** Months Days Min. 1 1 M 2 □ F Yrs Director 212-01-7286 93 Apr. 4, 1903 Maryland Usuai Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23s or 28s-f ahow any Injury or other traumatic avant, the Madical Examiner must be notified at 2008. 10a State 10b. County 10c. City, Town or Location 10d. tnside City Limita 1 ☐ Yes 2 No Director Maryland Baltimore County Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 Dulaney Valley Road Funeral 21204 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à Specify: 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Credit Manager
18. Mother's Name (First, Middle, Maiden Sumame) Oil Refinery 17. Father's Name (First, Middle, Last) Be 2 Patrick J. McEvov Catherine Brady 19e. informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard S. McEvoy 20a. Method of Disposition 129 Gloria Drive, Jacobus, PA 17407

20b. Placa of Disposition (Name of cemetery, crematory or other place)

PA 17407

20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Dulaney Valley Mem. Grdns3/21/97 Timonium, Maryland 22. Name end Address of Fecility Mitchell—Wiedefeld Home
6500 York Road, Baltimore, Maryland
23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, 2121 Approximate interval Between Onset and Death **Physician** /Medical immediate Cause (Final disease or condition resulting in death) Recurrent Stroke Examiner Due to (or as a consequence of) Examiner Dementia physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): attending Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Ponknown ap ed b p 24b. Were autopay findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 Yes ZIXNo 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical 26. Place of Deeth (Check only one) exeminer? 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 28a. Date of injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1/2Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, end due to the cause(s) and manner as steted. Medical 2 Medical Examiner: On the besis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

To the Hospital o within 24 hours at To the Funeral Di completely filled in

Ebrahim Ipakchi,

29b. Signature and title of effitter

M.D.2300 Dulaney Valley Rd 33. Begiever's Eignetu Randelle

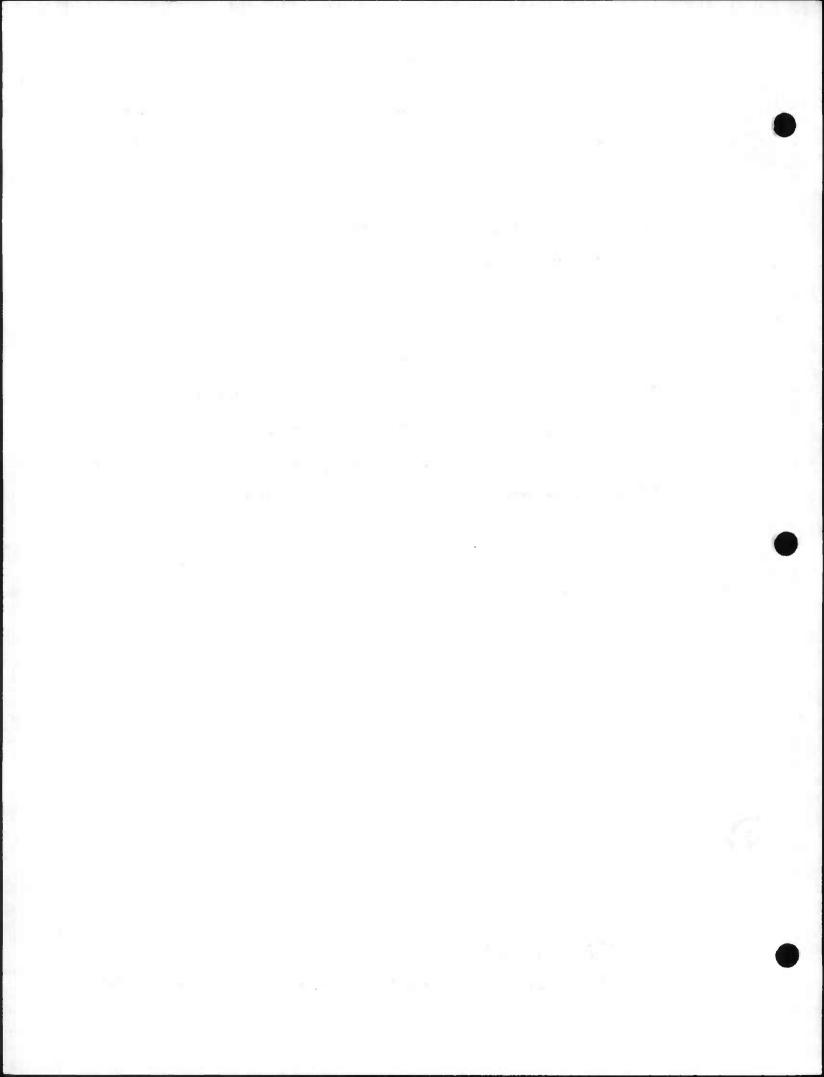
30. Name and address of person who completed cause of death (item 23a) (Type, Print)

29c. License number 25686

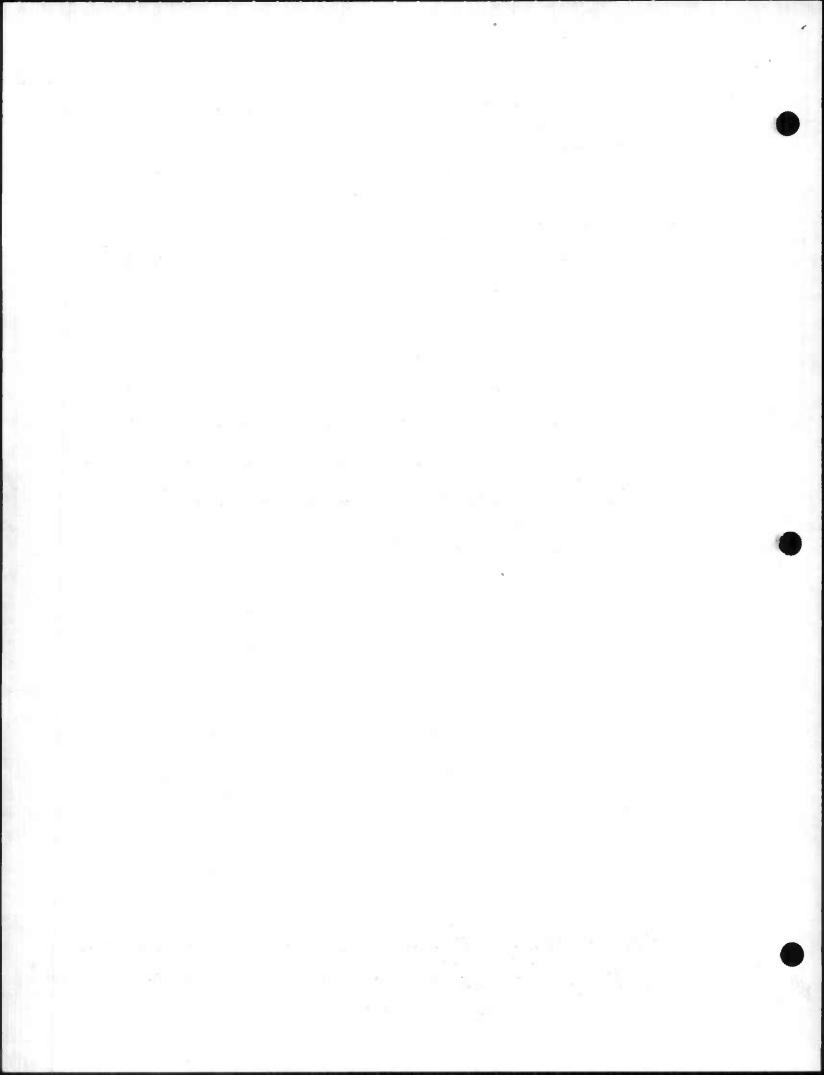
29d. Date signed (Month, Day, Year)

Towson, Md. 21204

State Registrar



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2		Mordie Leo	n Kirk					Maı	ıde Mayn	ard	Kin	rk	
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once. To Be Con		Mr. Thomas K. M	cNickle		7 C	Foa1	Cou	rt Coo	ckeysvill	e, M	D 2	1030	
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edical	2	Check only 21. Medical Ext	hysician: To the bes miner: On the basis	ot examinet	wledge, death	occurred	et the ti	me, dete end p	pleca, end due to the	e ceuse(s) end me	nner es st	eted.
Medical Certi	-		and menner	steted.						o, date of	iu piaca, e	3110 008 10	tile cause(s)
-	2	9b. Signature and title of defitifier	1 6	1.1		290	_	e number					Dey, Year)
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Physician

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Director:

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P.O. Box 68760.

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72 hours after

Baltimore, Maryland 21215-0020

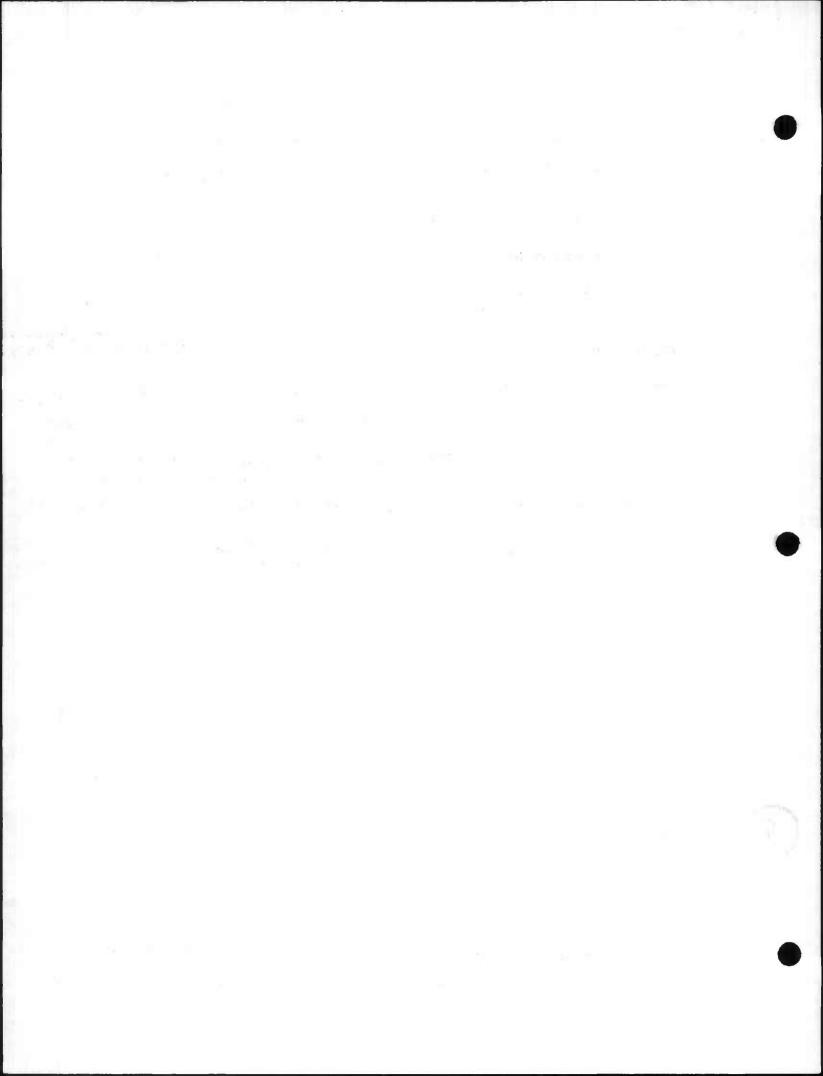
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** JOSEPH 15, McCRAY MARCH 1997 9:30 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 500 N. DUNCAN ST. BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) X M 2 F Days Yrs. 225-26-4559 70 03-30-26 VA Usuai Residence of Decedent 10a State 10b Count 10c, City, Town or Location 10d. Inside City Limits 1 Nes 2 No Director Md Na Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2216 Jefferson Street 21205 Funeral USA 12. Wes Decedent Ever In U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Merried 2 X Married 1 ☐ Yes 2 ☐ No Specify: by Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT use retired) Electric Hementary/Secondary (0-12) Collega (1-4or 5+) NA Baltimore Gas & Boiler Room 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur McCray Annie McNeals 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth 2216 Jefferson Street Baltimore, Maryland McCray 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Md. ₩ Burial 2 Cremation 3 Removal from State Garrison Forest Va Cem 03-20-97 Owings Mills, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Furtill Service Licensee 22. Name end Address of FecilityBaltimore, Maryland neo WM.C.March FH 1101 E. North Avenue 21202 Part I. Entar the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervat Between o schente Cordinal tmmedieta Cause (Finat disease or condition rasulting in daath) Dua to (or as a consequence of) Sequentially tist conditions, if any, leading to immadiata cause. Enter Underlying Cause (Diseasa or injury that initiated evants resulting in death) Lest Dua to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part ti. Other significant conditions contributing to death but not resulting in the undarlying causa givan in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown by 24a. Wes an autopsy performed? 24b. Were autopsy findings Completed available prior to completion of cause of death? 1 Yes 25. Wes case referred to medicat Be 26. Placa of Daath (Check only one) examinar? 1 ☑ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 2 ALLEY 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Magner of Daath 28d. Describe how Injury occurred 28b. Time of Certification: 28c. Injury et Work? 5 Pending Invastigation Naturat 1 ☐ Yes 2 ☐ No 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Medical 1 Certifying Phyetcian: To the best of my knowledga, daath occurred at the time, data and placa, end dua to tha cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) O.C.M.E. MARCH 15, 1997 30. Name and address of person who completed cause of death (I) cheodo no m 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) MAR 1 9 1997

64 State Registrar

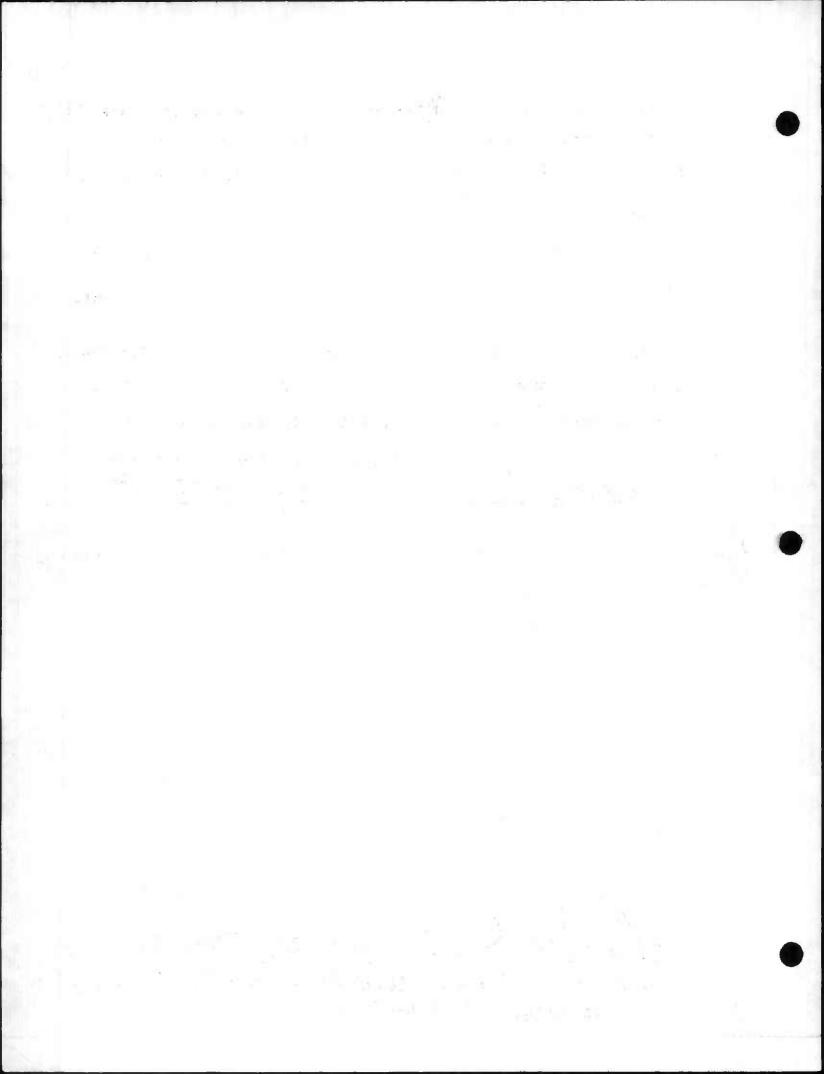


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Physician /Medical	ŀ	1. Decedent's Nama (First	lewicz							2. Date of D Month March	15, 199		3. Time of Deal 10:15 p
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		Usual Residence of Deced	ent		10c. (City, Town or L	ocation						0d. insida City Lir
Mariah Mariah Ctor		MARYLAND	N/A		DU	JNDALK							1√ Yes 2□
r flores 23a or 28a-f show after must be notified at Funeral Director		10e. Street and Number	H AVE	NUE			10f. Zip	Code 222			10g. Citizan	USA	ntry?
or items		11. Marital Status 1 □ Nevar Married 22 3 □ Widowed 4 □ Di		12. Was Dece Armed Fo 1 Tes If Yes, Giv Year or De	rces? 2 No		Was Deced If Yas, spec 1 ☐ Yes	1	lispanic Orlgin? (an, Mexican, Pua Spacity:	Specify Yas or Ninto Rican, etc.)	Spe	laca - Americ Black, White, city: WH	
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Mantal Hygiane. arked other than atic event, treat To Be Comp		17. Father's Name (First, N SYLVESTER		RKIEWI	CZ	20110	011011	ar () bar	18. Mothar's Na	ama (First, Middl DELENA	_		-11
important to fragin and wanter rygens. Important: If item 27 is marked other than "nature and in any or other traumatic event, the Medical price. To Be Completed		19a. informant's Name/Re MRS. PEARL 20a. Method of Disposition	MAZU	RKIEW]	20b.		DUL U	JTH e of	AVENUE		. MD.	vn, State, Zip 2122 n - City or To	2
ortant: if injury or		to Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ Ot				-	-		METERY	3-19	BALTO	. co.	MD.
ysician Medical aminer		23a. Part 1. Enter the dises shock, or heert failure Immediate Cause (Final disease or condition resulting in death)	ese, or comp List only o		ioscle	ath. Do not en	ter the mode	of dyir	DALK A) ng, such as cardia	ac or respiratory		MD.	21222 Approximata Interval Between Onset and Death
ettending physician and for use as the burial-transit clan/Medical Examiner		Sequantially list conditions if any, leeding to immediat leaves. Enter Underlying Causa (Disaase or Injury that initiated events resulting in death) Lest	1	b		or as a consec							
d by the ettendin letached for use Physician/N	1	Part II. Other significant co	nditions co	ntributing to de	ath but not re	sulting In the u	nderlying ca	use giv	en in Part i.	23b. Did	I tobacco use	contribute to	the cause of dea
be d	1	Chronie Ros Chechières t	roctee	ee Po	lorna	2 024	cone			24a. Wa	Yes 2□ No	24b. We	ere autopsy finding
has mp		Deventia	beaut	Faller	<u>. </u>						Yes 212 No	of	allable prior to mpletion of cause death?
his certific il director. To Be				28a. Date o		ER/Outpatier 28b. Time o Injury		Bc. Injur Wor	er: 41 Nursing	Home 5 Res			y)
within 24 hours after death. To the Funeral Director: After the Completely filled in by the funeral Medical Certification:		3 ☐ Suicide 6 ☐ 0	Could not ba	28e. Place buildin	of Injury - At I	nome, farm, str	reet, factory,	offica		28f. Location City or To	(Street and Nu	m <i>ber or R</i> ura	l Route Number,
he Funer pletaly fill edical		29a. Certifier 1 26 (Check only 2 Me	rtifylng Phy dlcai Examl	sician: To the l ner: On the ba and mann	sis of exemin	owledge, death etion and/or in	n occurred a vestigation,	t the tir In my o	ne, date and plac pinlon, death occ	e, end due to the surred at the time	ceuse(s) and , date and plac	manner es st e, and due to	ated. the cause(s)
Teth		29b. Signature and title of c		- Carlline	3				e number		29d. Date sig		Day, Year)
-10		00. Name and address of poor. Michael S					Print)			21225		,	
State Registrar		31. Date filed (Month, Day,	-	32. Re		ajure Par							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician /Medical		1 . 1 . 1 1 1		1	۸۸	. 4			2. Date of De Month	Day	Year	3. Time of Death
Examiner	-	4a. Facility Name (If not institution, giv.	C, a street and numbe	ar)	MORR	SW	4b. City, T	own, or Loc	March cation of Death	4c. County	1997 y of Death	0430
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neral ector		213 34 1030	ex 7.,	Age (In yrs.	last birthday) Yrs.	If Undar 1 Y Months D	ear if Unde ays Hours	Min.	8. Date of Bird (Month, Da July 24	v. Year)	9. Birthplac Country, Maryl	e (Stata or Fore) Land
284-1 show	-	Usual Residenca of Decedant 10a. State 10b. County		10c. Cit	ty, Town or Loc	ation					10d.	Inside City Lim
thed a	2	Maryland Harfor	rd .				Aber	deen				1 Yes 2
at be notified		10e. Street and Numbar 200 Perry Woods	Ct.			10f. Zip Co	^{da} 21001			10g. Citizen of United		
leted by Funeral Director	2	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorcad	12. Was Decedar Armed Forca 1 Yes 2 If Yes, Giva Year or Datas	s? ₫No		/as Dacadent Yes, specify			cify Yas or No Rican, etc.)	14. Rad Bla	ca - American ck, White, etc	
Completed	Daniblette	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12		r 5+)	16a. Deced (Give life. D	O NOT use re	ccupetion one during mo etired)	st of workin	ng	16b. Kind of B		corator
B		17. Father's Nama (First, Middle, Last)	Vorge		1		18. Moth		(First, Middle,	Maiden Suman	na)	
P	2	Clarence R. 19a. Informant's Name/Relationship (7)	Morrow		10h Mailin	Address (Ct	Ver		I Courte Mumbe	r, City or Town,	Hilbert	
		Linda C. Poindex		ster							, <i>Siate, Zip Co</i> 7058	ode)
a company	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from Stat	9	Placa of Dispos cemetary, crem			3/19	Date 9/97	20c. Location	- City or Town	
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es the burial-transit		Sequentially list conditions, f any, leading to immediate cause. Enter Undarlying Cause (Diseasa or Injury hat initiated events resulting in death) Last	b	1-10-10-10-10-10-10-10-10-10-10-10-10-10	or as a consequ	CALL OF THE					1	0
for use e			d									
by Physician/M		Part II. Other significant conditions co	entributing to death	but not resi	ulting in the un	derlying cause	given in Part	1.		obacco use co ree 2 No	ontribute to the	e cause of deat
Completed b									24a. Was perfor		availal	autopsy findings ble prior to etion of cause th?
Comp									1 U Y	as 2000	1 □ Y	es 20 No.
o Be		25. Was case referred to medical examiner?	Hospitel: A	N1 00	5000		Other		(Check only o			
tlon: To		7. Menner of Death Natural 5 Pending Investigation	28a, Date of In (Month, D	ury	ER/Outpatient 28b. Time of injury	28c. I	njury at Work? 1 Yes 2	2		enca 6 □Oth ow Injury occur		8 -01
Certification:		3 Suicide 6 Could not be determined	28e. Place of le building, e	njury - At ho etc. (Specif)					8f. Location (S City or Tow	treet and Numb n, State)	per or Rural Ro	oute Number,
completely filled in by the funeral Medical Certification: 1		29a. Certifier (Check only one) Medical Exam	sician: To the bes iner: On the basis and manners	of examinat	wiedge, death o tion and/or inve	occurred at the	e time, date ar ny opinion, des	nd placa, ar ath occurred	nd due to the o	ause(s) and me ate end place,	anner as stete and due to the	d. e cause(s)
comple		9b. Signature and title of certifier	wy X			29c. Lic	ansa number	e	7	9d. Date signed	d (Month, Day	(, Year)
1						VVV	1 -	-1	0 1	-UIV		1 /



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Mary E. Michael 9:30 A.M. 1997 March 16 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7809 Elizabeth Road Pasadena Anne Arundel 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey,) Feb. 24, 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 1 M 2 F Months Deys Hours 413 24 8309 Yrs. 71 1926 Tennessee Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7809 Elizabeth Road 21122 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced White 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Bookkeeper Construction 12th 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Jewell Hughes Shady W. DeFriese 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 37421 Laban DeFriese Brother 6420 Shallowford Road Chattanooga, Tennessee 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Pk. 3/18/97 Baltimore, Maryland 21. Signature of Funerei Servica Licansee 22. Name and Address of Fecility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 americuste 23a. Pert1. Enter the disease, or complete shock, or heart feilure. List only of the flows that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, a cause on each line. Approximate Intervel Between Onset end Deeth sewm Immediete Cause (Final disease or condition resulting in death) es a consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Wes en eutopsy

Physician /Medical Examiner

attending physician end for use es the bunal-trensit the death certificete be executed

signed by the a d be detached

ate hes been signated by page 2 should b

certificate

After

To the Hospital or Attanding within 24 hours effer death.

To the Funeral Director: Afte completely filled in by the fun

funeral

Box 68760,

P.0.

Division of Vital Attanding Physician: **Physician**

/Medical

Examiner

Director

Funeral

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Completed

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Physician/Medical

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Certification:

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r than "natural", or items 23s or 28s-f sho the Medical Examiner must be notified at

al Hygiene.

. Peges 1 and 2 should be fill iment of Health end Mental Hitant: If item 27 Is marked oth

permit. Peges 1 end 2:
Department of Health er
Important: If item 27 la
any injury or other trau

with the Maryland

death

Baltimore, Maryland 21215-0020

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest

28. Piece of Deeth (Check only one)

24b. Were eutopsy findings evaileble prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Wes case referred to medical 1 Yes 2 No 27. Menner of Deeth

Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred

1 Neturel 2 Accident 3 Suicide 4 Homicide

28e. Dete of tnjury (Month, Day Year) 5 Pending investigation 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 Yes 2 No

29a. Certifier (Check only one) 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of cartified

29c. License number

Bluz.

29d. Date signed (Month, Dey, Year)

30. Neme and address of

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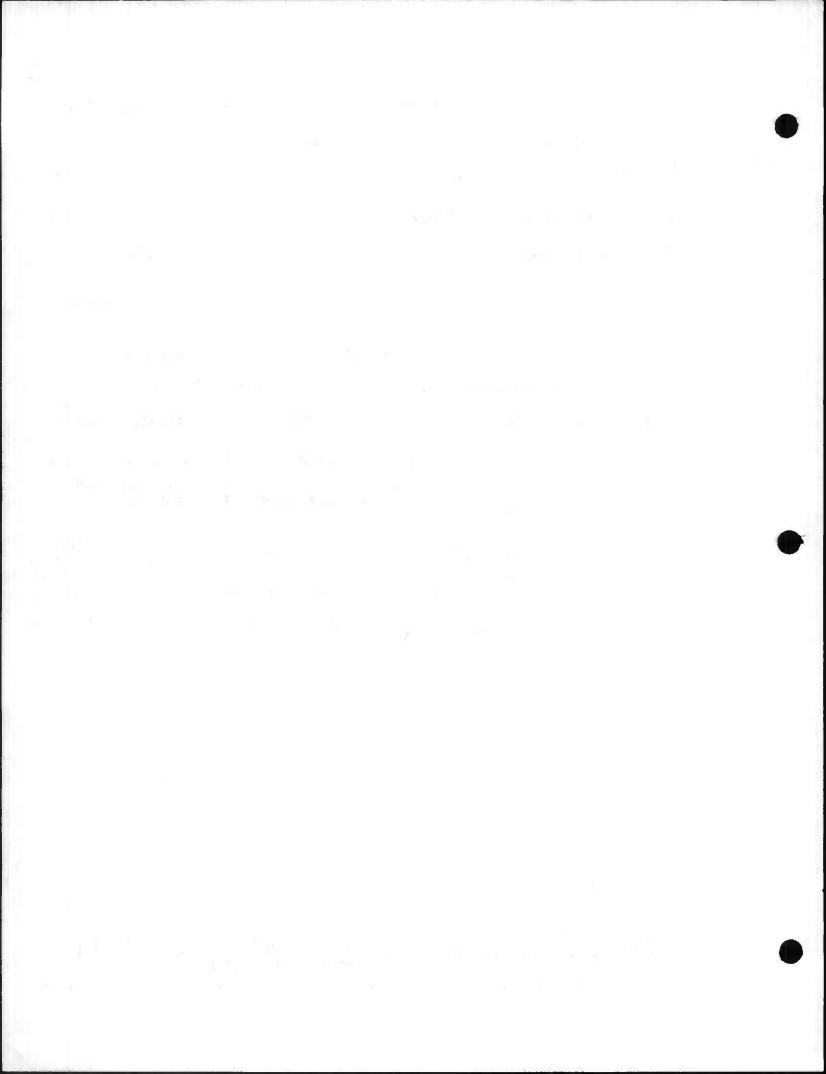
rson who completed cause of death (Item 23a) (Type, Print) - Annapolu

Jerry

31. Dete filed (Month, Dey, Year)

32. Registrer's Signeture and wirdson

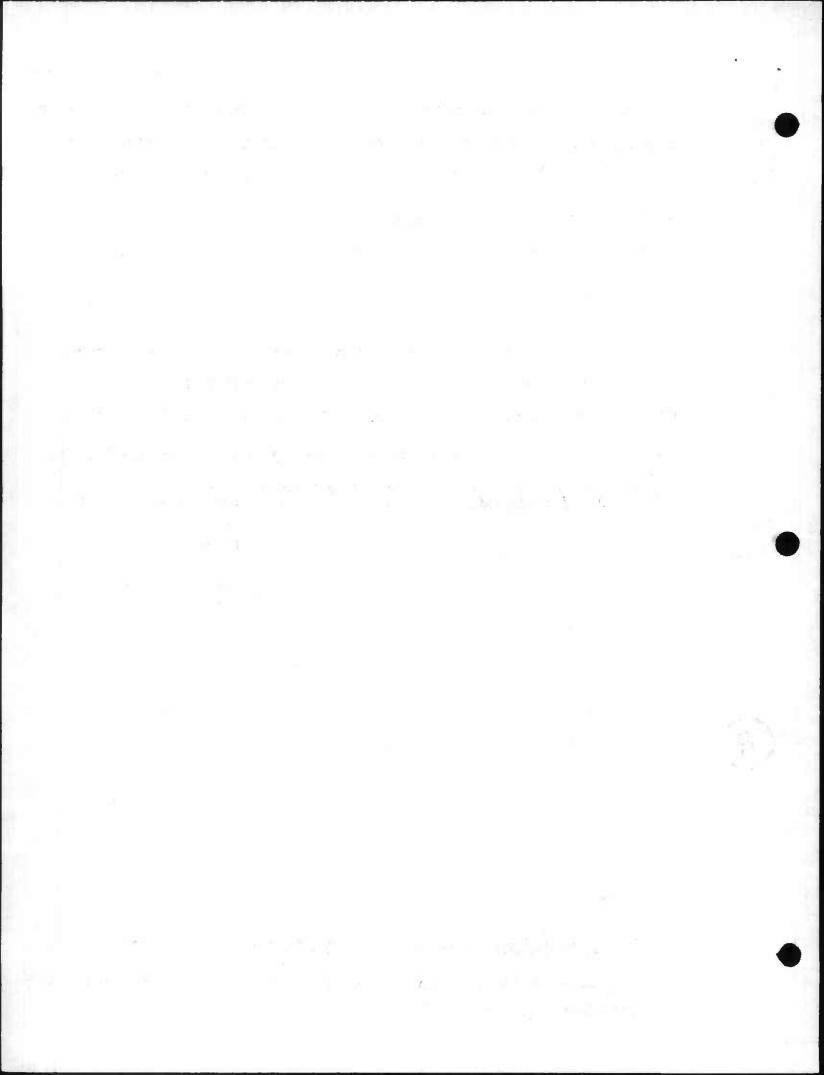
State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 17, EDWARD FARRELL MADDOX 1997 MARCH /Medical 1:46PM 4e. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 6. Sex 1/2 M 2□ F 7. Age (in yrs. last birthdey) If Under 1 Yeer | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
July 29, 1931 9. Birthplece (State or Foreign Country)

Maryland **Funeral** Days 214-26-5040 65 Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location r 28a-f show Inotified at 10d. inside City Limits Directo Maryland Baltimore 1 Yes 2 No White Marsh 8 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be n 5807 Pine Hill Drive 21162 Horne 23a U.S.A. Completed by Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian. r than "natural", or iten the Medical Examiner. Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 No If Yes, Give 21215-0020 1 Yes 2 X No Specify: Specify: White it Yes, Give Yeer or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) Coilege (1-4or 5+) Parole Commissioner State Government Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If then 27 is merked othe any Injury or other traumatic surve-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) William Edward Maddox Elizabeth Doolev 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)
5807 Pine Hill Drive White Marsh, Md. 21162 Wilda L. Maddox (wife) 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 XBuriel 2 ☐ Cremetion 3 ☐ Removal trom State Holly Hill Mem. Gardens 3/20/1997 Baltimore Co., Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa re of Funerel Service Licencee 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue 21221 Essex, Md. 23a. at 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shyck, or heer tailure. List only one ceuse on each line. Physician /Medical Immediate Cause (Final Ventricular 30 mm disease or condition resulting in death) Examiner Examiner CARDIOMYOPA at the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last pue Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medicai Due to (or as e consequence of): the & Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 Dlabetes 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was en eutopsy performed? 1 ☐ Yes 2 No After this certificate 1 Yes 2 No Division of Vital Attending Physician: Be 25. Was cese reterred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1,⊠npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 5 Pending death. 1 Yes 2 No or Attendi after death Director: A 2 Accident Investigation in by the 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours a To the Funeral D completely filled 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, dete and piece, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and a dress of person who completed ceuse of deeth (item 23e) (Type, Print) 1401 Oslep Dr. Bolto Bi OBISON and 32. Registrar's Signatore and see State Registrar



State of Maryland / Department of Health and Mental Hygiene

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)	Exami		4a. Facility Neme (If not Institution, giv					own, or Location of Dea	th 4c. County o	Deeth				
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	Director		240-14-0434	Q (M 2□ F	82 Y	rs.	Deys Hours	Feb.	20 1915 N	ORTH CAROLINA				
	land		Usuel Residence of Decedent 10a. Slete 10b. County	100	c. City, Town	or Location				10d. Inside City Limits				
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	with the Marylan a or 28a-f ahow be notified at	Director	10e. Street and Number			10f. Zip	Code		10g. Citizen of Wi	nat Country?				
	ath w		939 W. LEXINGTON				223		U.S.A.					
2	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-1 show the Madical Examine: must be notified at	/ Funeral	11. Maritel Stetus 1 Never Merried 2 Merried	12. Wes Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give	in U,S.	13. Wes Deced If Yes, spec		Igin? (Specify Yes or N n, Puerto Rican, etc.)	o- 14. Rece Bleck Specify:	- American Indlen, , White, etc.				
0200-91212	n 72 hours aft "natural", or I	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:					BLACK					
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<u> </u>	d2st thanc 7 Is m traun		19e. Informent's Neme/Reletionship			_		er or Rurel Route Num.						
e è	Heaith Hem 27 other to		Francine Matthews 20a. Method of Disposition		0b. Plece of I	Disposition (Ner	ne of	Dete Dete		Maryland 21223 Oity or Town, Stete				
altimore,	artment of octant: If Ik Injury or o		1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	9		JS MEMOR	IAL PARK	3-21	BALTIMOR	E, MARYLAND				
pall	Depart Import any in	1	21. Signature of Emeral Service Licensee 22. Name end Address of Fecility WILLIAM: C. BROWN COMMUNITY F/H 1206 W. NORTH AVENUE 23a. Part 1. Enter the disease, or described on the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between											
	25 (20)		23a. Part1. Enter the disease, or down shock, or heart failure. List only	scations that caused the one cause on each line.	death. Do no	ot enter the mod	e of dying, such as							
	Physician /Medical Examiner		Immediate Cause (Final disease or condition	· RASPI	RAT	DR 4	EA	YLURF		24 H7				
	- Xariiii lei	L	resulting in death)		to (or as a or	onsequence of):								
	uted 1 anek	Examine		6 CHMONI	16	0355	MIN	F PULL	ONMY	20 420				
5	an an riai-tn		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due	to (or as a or	onsequence of):	1) 13	118211						
09/90	physici the bu	edical	Cause (Disease or injury that initiated events resulting in death) Last	C. Due	to (or as a co	onsequence of):								
	원 명생	-												
BOX	를 들고	cian												
ġ	the de sythe	Physician/N	Part II. Other significant conditions of	ntributing to death but no	t resulting in	the underlying o	suse given in Part I	5.00		ribute to the cause of death?				
,	aigned by to signed by to id be detach	by P							THE ZLIND	aCl Property 459 outstown				
records	v require been sig should t								s an autopsy omed?	24b. Were autopsy findings available prior to				
ě	Pass by Pass b	Completed								completion of cause of death?				
H H	al al							10	Yes 2527No	1□Yes 2DNo				
-	1 000	o Be	25. Was case referred to medical examiner?	Hospital:	o Planta V		04	of Death (Check only						
0	RI	1-	27. Margelir of Death	28s. Date of Injury	2 ER/Outs 28b. Ti		8c. Injury at Work?	ursing Home 5 Per 28d. Describe	how injury occurre					
		atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		ir) In	M M	Work? 1 ☐ Yes 2 ☐	No:						
SINIS	or Atta after de Directo in by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp	At home, farr secify)	m, street, factory	, office	28f. Location City or To	(Street and Number own, State)	r or Rural Route Number,				
	ours eral		29a. Certifier 12 Certifying Phy	sician: To the best of my	knowledge,	death occurred	at the time, date an	nd place, and due to the	cause(s) and man	ner as statud.				
	To the Hos within 24 h To the Fun completely	edical	(Check only 2 Medical Exam	iner: On the basis of exar and manner stated.	mination and	for investigation,	in my opinion, dea	ith occurred at the time	, date and place, ar	id due to the cause(s)				
	To the within 2 To the comple	×	29b. Signature and title of certified				License number	30	29d. Date signed	(Month; Day, Year)				
)	6		Jan Jo				12/8	38	211	/				
	9		30. Name and address of person who o	ompleted cause of death	(Item 23a) (T 	S 18	CANO	DISAN	nan	10 21090				
ı	Sta Registr	11	31. Dete flied (Month, Dey, Year) MAR 1 9 1997	39. Registrar's S	Signeture	della		131111	0.17	10				

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State of Maryland / Department of Health and Mental Hygiene

Item 27 per PHY Film G745 3-18-97 rja Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** MATTHEWS 4ALLIE /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** CHURCH BALTIMORE
If Under 24 Hrs. 8. Dete HOME HOSPITAL If Under 1 Year 5. Sociel Security Number 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1□ M 2⊠F Months Deys 219-32-5538 77) Yrs. OCT, 19,1926 SOUTH CAPOLINA Director Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show solds! Examiner round be notified at 1 Yes 2 No Director MARYLAND 10e. Street end Number BALTIMORE CIT 10g. Citizen of What Country? 908 AVENUE MILTON Completed by Funeral USA Peges 1 and 2 should be filed within 72 hours efter death nent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or itema 23.
Inty or other traumatic event, the Modrial Examinal matal. 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 No If Yes, Give Yeer or Dates: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK 3 Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 8+++GRADE Coilege (1-4or 5+) OWN HOME HOMEMAKER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) OTIS DUCKETT VERA DUCKETT 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) JOHN R. MATTHEWS (HUSBAND) 908 N. MILTON AVE., BALTIHORE HD. 2/12 05.

20b. Piece of Disposition (Name of Disposition (Name of Disposition) 20e. Method of Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other place) W Buriai 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Pege Department of Important: If any Injury or GARRISON FOREST CEMETERY 3-18-97 OWINGS MILLS, HD. 4 Donetion 5 Other (Specify) 21. Signatura of Fundral Service Licens 22. Name and Address of Facility JOSE PH H. BROWN JR. FUNERAL HOME, P. A. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest,

Approximate

Approximate Physician 6 days /Medical Immediete Ceuse (Finei Cerebrovarcular Accident disease or condition resulting in deeth) Examiner Due to (or es e consequenca of) Examiner The lew requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? HyperTen gron 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Records, 2 24b. Were autopsy findings eveileble prior fo completion of cause of deeth? Be Completed 24e. Wes en eutopsy performed? this certificate hes 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth Medical Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury ef Work? 5 Pending investigetion 1 Naturei 1 Yes 2 No 2 Accident efter death filled in by the 6 ☐ Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homlcide To the Hospital o within 24 hours eff To the Funeral Di completely filled in The Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) dud- Speciality 30. Name end eddress of person who completed cause of doubth (liem 23e) (Type, Print) BALTIMORE MARYLAND 21231 WENEUSA T. NAVARRO 100 N. BROADWAY, 31. Dete filed (Month, Day, Year) MAR 1 9 1997 32. Degistrer's Signeture State Registrar

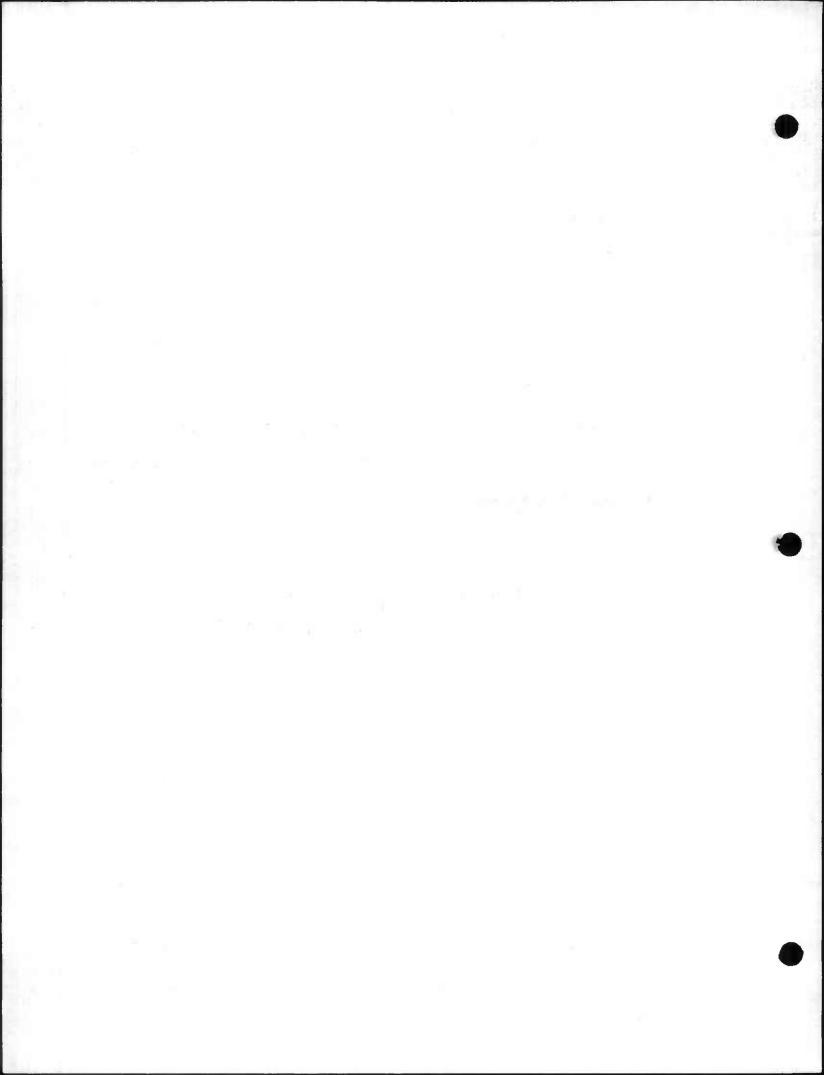
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State of Maryland / Department of Health and Mental Hygiene

					, y laira ,		icate of	Death	Wientan Try	Reg. No.	97	084	173		
	Physic /Medi		Decedent's Name (First, Middle, Las	Dale Mit	chell				2. Date of De Month March	eath Day	Year 997	3. Time o	of Death		
	Exami		4e. Facility Name (If not institution, give 1724 Old Easte					4b. City, Town, or Essex					PALIL		
	Funerai Director		5. Social Security Number 6. Se	7. Age	(In yrs. last b		Under 1 Yeal onths Days	If Under 24 Hrs	(Month, De		9. Birthple Count 7 Wes	ece (State ory)	or Foreign		
Aeryland	f show	5	10a. State 10b. County Maryland Baltimo		_	wn or Locatio	n				10	d. Inside C	City Limits		
with the	s or 28a- t be notif	i Direct	10e. Street and Number 1724 Old East		1.		Of. Zip Code	21.221		10g. Citizen of 1					
020 urs efter deeth	s 1 and 2 should be filed within 72 hours effer deeth with the Meryland if Heath and Mentel Appiano. If Heath and Mentel Appiano. Other traumatic event, the Medical Examinations to be holded to the first first first for the first of the first fir	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ex Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates:			Decedent of s, specify Cul	21221 Hispanic Origin? (Span, Mexicen, Puer	Specify Yes or No to Ricen, etc.)	U.S 14. Rac Blac Specifi	ce - Americe ck, White, e	tc.			
121 within		Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	a. Decedent's (Give kind life. DO N		pation a during most of wo	rking	Baltimore Cou Board of Educ		ustry	on		
aryland 2	ked other ic event, it	To Be C	17. Father's Neme (First, Middle, Last)	Jeff Mit	che11	74000 a. 1	. dir	18. Mother's Ne	me (First, Middle	, Maiden Sumen	0				
	of treumet	-	19a. Informant's Name/Reletionship (7) Mrs. Mary Mitchel					t and Number or R	ural Route Numb	er, City or Town,	,	,			
Baltimore,	Pages 1 and 3 nent of Health Int: If item 27 I		20a. Method of Disposition 1 🔀 Burial 2 Cremetion 3 🗆 4 Donation 5 Other (Specify,	Removel from State	20b. Place cemer	of Disposition ery, cremetor	n (Neme of ny or other pla		Date 3/11	20c. Location -	- City or Tow	vn, State	raini:		
Balt permit.	Department of Important: If it any injury or o		4 Donation 5 Other (Specify) Fansler Cemetery 3/11 Hendricks, West Vi 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Service 3981Carrollton Road Upperco, Maryland 21155												
	ysician Medical		23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximately the mode of dylng, such as cerdiac or respiratory errest, interval onset as timediete Ceuse (Finel disease or condition												
	caminer	lner	resulting In deeth) a. Due to (or as a consequence of):										9.5		
68760, tificate be executed	g physician and es the bural-trensit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	. Cerel	010 -	Consequence	ce of):		dent			yeo.	15.		
Box 68	ending phy r use es th	an/Medi	d									0			
P.O.	igned by the attendin be deteched for use	by Physician/M	Part II. Other eignificant conditions co	iven in Part I.		tobacco usa co Yes 2□No	10	the cause of							
ecords law requires	pluode	Completed b								an autopsy ormed?	aval	re autopsy f llable prior t apletion of c eeth?	to		
ital R	certificate hes l rector, pege 2 s	Ве Соп	25. Was cese referred to medical					26. Piece of De	ath (Check only o	/	10	Yes 2	No		
Division of Vital Records, for Appending Physician The law requires the	In this pertific	2	27. Menner of Death 1 Naturat 5 Pending	Hospital: 1 ☐ Inpatient 28a. Dete of Injury (Month, Day)	28b.	Outpatient 3 Time of Injury	28c. Inju	her: 4 Nursing F	tome 5 Resi						
Divisi	rs efter al Dir led in blime	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	y - At home, f (Specify)				28f. Location (City or To	Street and Numb wn, State)	er or Rural	Route Num	iber,		
Mospi	within 24 hours effer To the Funeral Director completely filled in t	edical	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of ner: On the basis of e and manner state	xamination a	ge, death occ nd/or investig	urred et the t pation, in my	me, date and place opinion, deeth occu	e, and due to the urred at the time,	cause(s) and ma date and place,	and due to t	ited. the cause(s	3)		
Toth	Toth	M	29b. Signature and title of confiden	_			_	se number - 1929		29d. Date signe	d (Month, D	ley, Year)			
	6		30. Neme and address of person who co	Ses 91	,05	(Type, Print)	n Sap	Five S	1430	19 B	of15	CEE.		
	Sta Registr		31. Date filed (Month, Dey, Year)	32. Registrar	s Signature	delle		O							

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Items23PartI,23 PartII State of Marylar 4-7-97 FilmG746 NtemPET Per PHY Film G745 3-18-97 rja State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) EVELYN Month B, 2 MAGSAMEN **Physician** /Medicai 4a. Facility Neme (If not institution, give streat end number 4b. City, Town, or Location of Death Examiner Church Nursing Center Baltimore Sex 7. Age (In yrs. last birthdey) If Under 1 Yaar If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) August 5, 1910 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Director 215-01-0667 Maryland Usuel Residence of Dacedent 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 Vas 2 No Maruland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ö or items 23a 125 South Potomac Street 21224 U.S.A. Funerai 12. Was Decedent Ever in U,S. Armed Forces? 14. Reca · American Indien, Bleck, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 Nevar Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Giva Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Spacify: White by 3 ☐ Widowed 4 ☐ Divorced Specify: natural', Completed 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiane. Elementery/Secondary (0-12) College (1-4or 5+) Office Clerk Insurance Company 12th grade 17. Fether's Neme (First, Middle, Last) permit. Pages 1 end 2 should be file Department of Health end Mental Hy Important: if Itam 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Sumema) Be Effie Seidenstricher Robert R. Magsamen 19e. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Leonard P. Magsamen (Nephew) 228 Elinor Avenue, Baltimore, Maryland 21236 20e. Method of Disposition 20b. Placa of Disposition (Neme of cemetary, cremetory or other plece) Dete 20c. Location - City or Town, Stata 1 X Burlei 2 Crametion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Park Baltimore. Maryland 21. Signatura of Funerel Servica Licansee 22. Name end Address of Fecility Schimunek Funeral Home 3331 Brehms Lane, Baltimore, Maryland 21213 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrast, shock, or heer feilura. List only one ceuse on each line. Renal Failure **Physician** Immediate Cause (Final disease or condition resulting In deeth) /Medical ACUTE LOKS Examiner Physician/Medical Examiner Sepsis and Dehydration that the death certificate be axecuted bunal-transit Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting In deeth) Last and Due to (or es e consequence of): Clostridium Difficile Enteritis P.O. Box 68760. the Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t Aspiration, Bed Sores 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ cords, Be Completed 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitel: 1 Impatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpetlent 3 DOA Division of s efter death.

Il Director: Aftar this
d in by the funeral d 27. Menner of Deeth 1 (Whetural Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending Invastigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Straat and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e To the Funeral D completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 017322 PEB. 28.1997 Norsem n 10 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) CHURCH HOSPITAL, BALTIMO

State Registrar

MAR 1 8 1997

31. Dete filed (Month, Dey, Year)

3 Registrer's Signeture Randoll

ASSESSMENT OF THE PARTY.

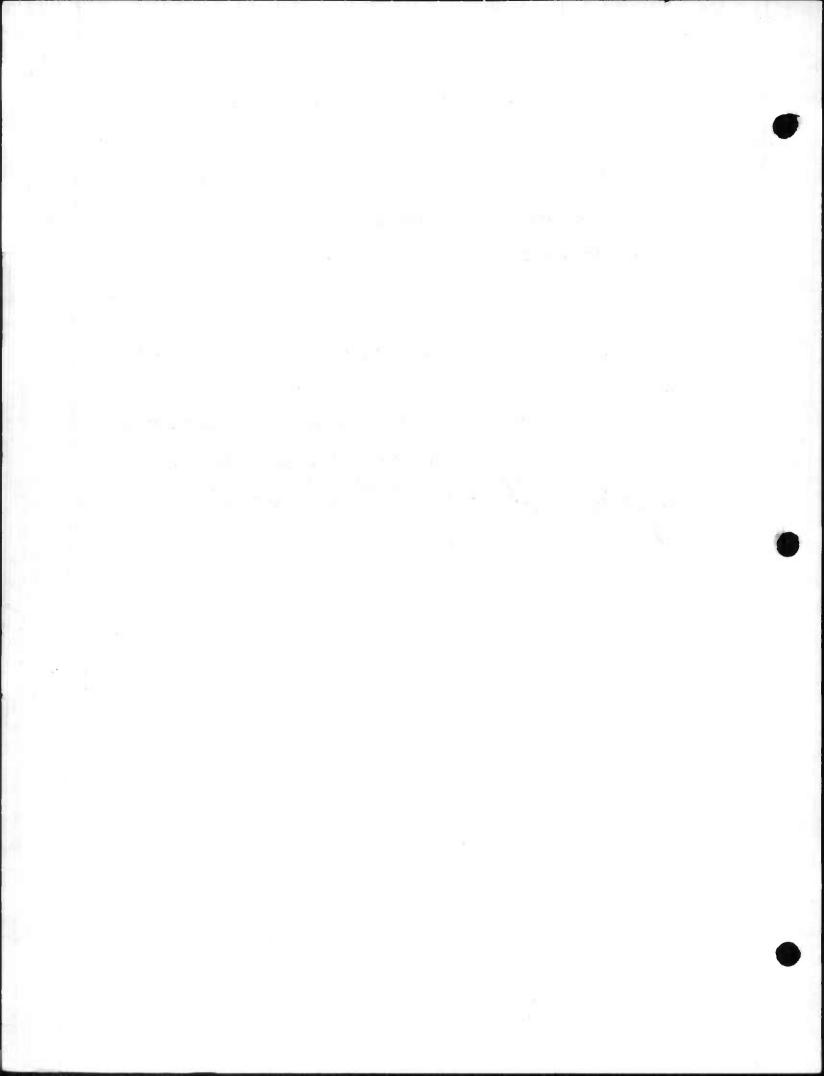
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State Registrar 31. Pate filed (Month, Dey, Year) MAR 1 9 1997

Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

12 Registrar's Signature

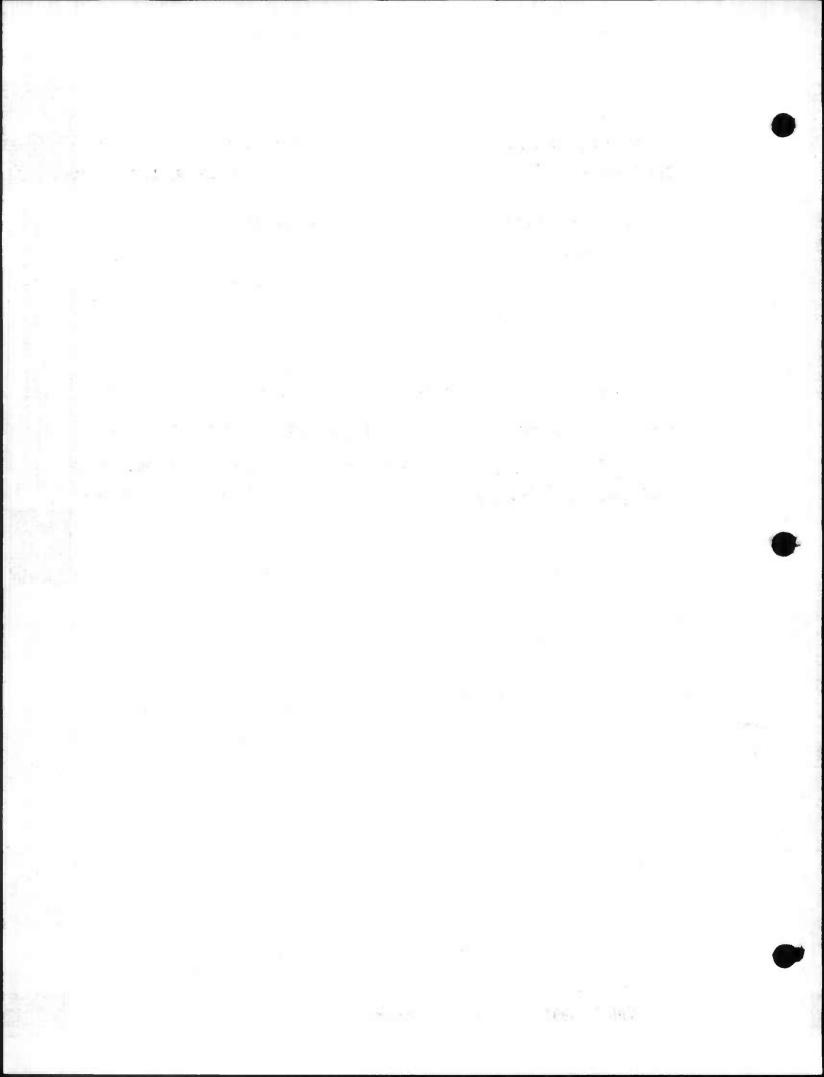
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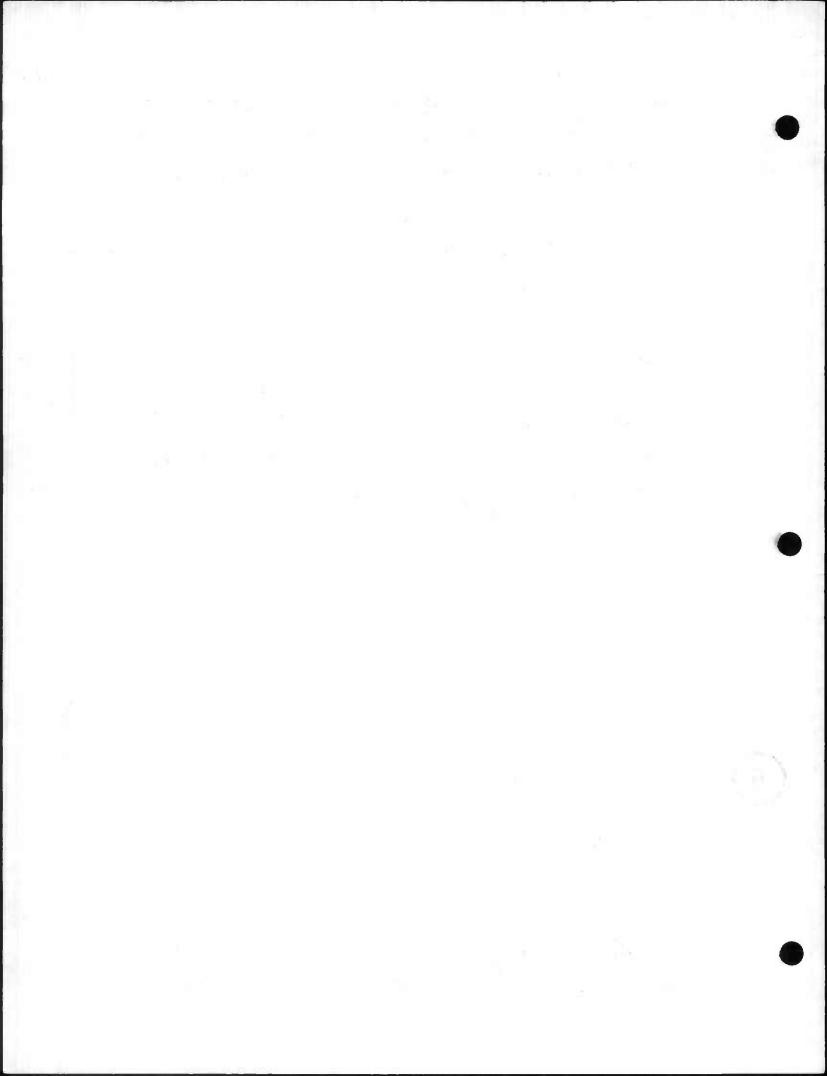
_		I	tem 19b per FH Film	G745 3-18-9			tificate of	Death		Reg. No.	97 0	8476		
	Physic /Medi		1. Decedant's Nama (First, Midd	M	aia				2. Data of De Month	Day 15-fes	Year /997	Tima of Deeth		
	Exami	ner	4a. Facility Nama (If not institution					4b. City, Town, or	Location of Death	4c. County	of Death			
			LEVINDALE				Wilderdon d Money	BALTI			N/A			
	Funeral Director		5. Social Security Number 213–28–9819	6. Sex 1 X M 2 □ F	7. Aga (In yrs.	78 Yrs.	If Under 1 Yaar Months Days		8. Data of Bird (Month, Da MARCH	12, 191	9. Birthplace Country) 9 G	(Stata or Foreign ERMANY		
	the Maryland 28e-f show	2	Usual Rasidance of Decedant 10a. Stata 10b. County		10c. Cit	y, Town or Lo	cation					nside City Limits		
	N of Party	SC SC		ALTIMORE				BALTIMOR				□ Yas 277No		
	th with the Maryla 23a or 28a-f shout the notified at	Director	10e. Street and Number 3106 MARNA	AT ROAD			10f. Zip Coda	21208		10g. Citizan of V	What Country?			
	eath F 2	era	11. Marital Status		edant Ever in U	S 13 \	Vas Decedent of		Specify Vas or No	14 Bac	e - Amarican In	dian		
020	should be filed within 72 hours after death with the Maryland nd Mental Hygiene, marked other than "natural", or items 23a or 28a-f show imatic event, tra Medical Examiner must be notified at	by Funeral	1 Nevar Marriad 2 Mar 3 Widowed 4 Divorced	ried 1 ☐ Yas	rces? 2₩No va		Yas, specify Cub	Hispanic Origin? (Span, Maxican, Puar Specify:	to Rican, atc.)		ck, Whita, atc.			
Maryland 21215-0020	within 72 hours ene. than "natural", ta Medical Exe	Completed	15. Deceder (Specify only higha Elemantary/Secondary (0-12)	nt's Education est grada complated)	I-4or 5+)	16a. Deced (Giva lifa. L	ant's Usual Occu kind of work dona OO NOT use retire	pation during most of wo	rking	16b. Kind of Bo	usiness/industry	,		
21	od withingiene.	Con	8			LABOR	ER			FACTO	RIES			
pu	il the s	Be	17. Fathar's Nama (First, Middla,	Last)				18. Mothar's Na	ma (First, Middla,	Maidan Sumer	na)			
yla	2 should be filed with and Mental Hygiene is marked other that reumatic event, to	To	ISIDORE		MA	IER		FLOREN	Z		WOLF			
Jar	D		19a. Informant's Name/Ralations	ship (Type, Print)		19b. Meilin		t and Number or R	ural Routa Numbe	er, City or Town,	Stata, Zip Code	9)		
Baltimore, N	es 1 and of Health f Item 27 r other to		KURT MAIER / E			lace of Dispo	MARNAT MARNOT Siltion (Nema of natory or othar pla		LTIMORE Data		208 City or Town, \$	Stata		
Ë	Pa men		4 Donation 5 Dother (S	ipecity)	CH CH	EVRA A	HAVAS CH	IESED	3/17/97	RANDAL	LSTOWN,	MD		
Sal	permit. Pag Department Important: I any Injury o		21. Signature of Education 3 Ramoval from State CHEVRA AHAVAS CHESED 3/17/97 RANDALLSTOWN 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 Reisterstown Road Pikesville, MD											
ш	ZOE # 8		Y/////////											
	Physician /Medical Examiner	Examiner	Immediate Causa (Final disease or condition resulting in death)		Dua to (o	Ca or as a conseq nary	dio - puence of:	sulmo.	nary	arrist		val Batween at and Death		
Box 68760,	death certificate be executed attending physician and if for use as the burial-transit	edical	Sequentially list conditions, if any, leading to immadiata causa. Enter Undarlying Cause (Disease or Injury that initiated events rasulting in death) Last	c	Con	ras a consequence of as a consequence	ne !	heart	fail	vre.				
	10 m 10	sici	Part II. Other significant condition	ons contributing to de	eath but not rase	uiting in the ur	idarlying causa gi	ivan In Part I.	23b. Dld 1	obacco use co	ntribute to the	cause of death?		
8, P.O.	ed by the	by Phy	prospte 1	Caranon	70-	he	per te	45102	10	Yee 2□ No	3 Probably	4 □ UTTKnowi		
ecord	R)	Completed by Physician/M	didsetes n	Carcinon mellitus		5/1	cerebra	o vaseu	24a. Was perio	an autopsy med?	availabl	utopsy findings a prior to ion of causa i?		
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Division of Vital	Attending Physicians or death. sctor: After this certific by the funeral director.	Certification:	1 Natural 5 Pendir 2 Accidant Invasti 3 Suicide 6 Could detarm	gation not be pined 28a. Place	of Injury - At ho	oma, farm, str		Yas 2 No	28f. Location (S	Street and Numb	per or Rure! Rou	ita Number,		
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	n 24 n Fu yetet	edical	(Check only one) 2 Medical	Examinar: On the be	asis of axaminat nar stated.	tion and/or Inv	astigation, in my	opinion, death occu	urred at tha tima,	data and place,	and due to tha	causa(s)		
	within To the Comp	×	29b. Signatura and titla of certifia	Ir ,			29c. Licen	sa number		29d. Data signe	d (Month, Day,	Year)		
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DHMH 16 Rav 6/95



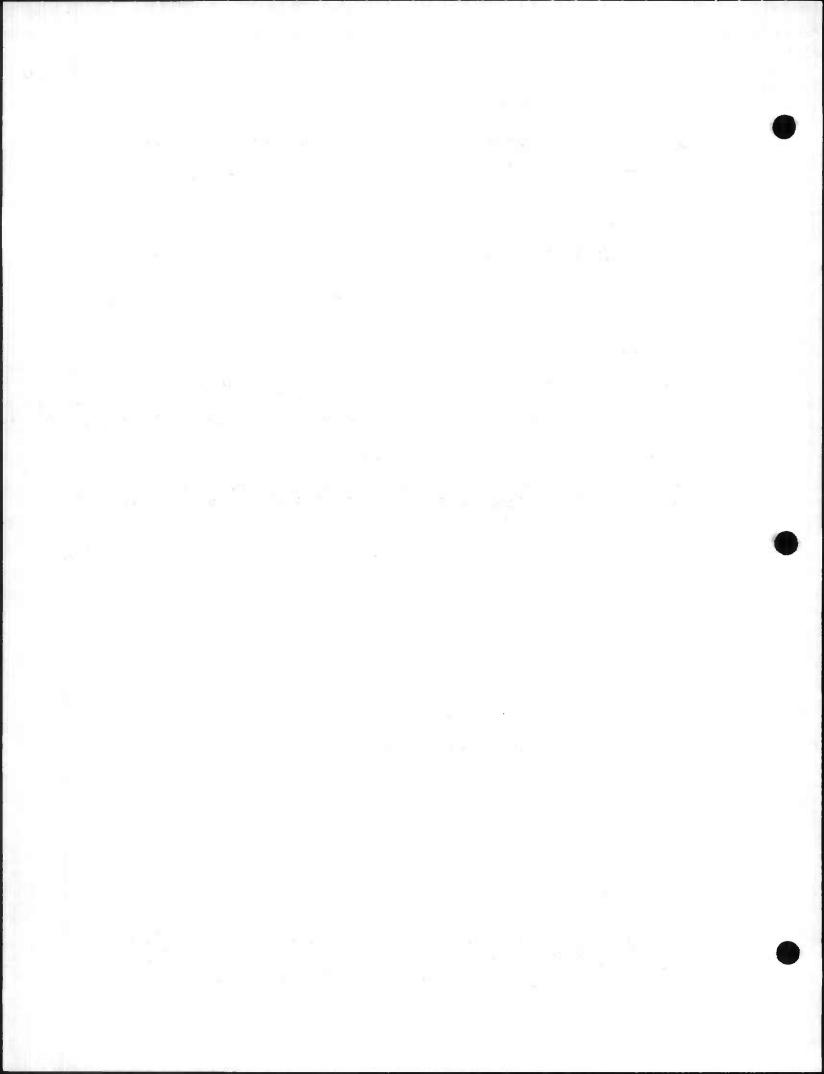
State of Maryland / Department of Health and Mental Hygiene

Items#23.27.FilmG746 4/16/97 kam Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** GREGORY MARCH 14ay 1989 NEWBORN 1721 M /Medical 4a. Facility Nama (If not institution, give street and number)
26 SOUTH EXETER STREET APT.6-H 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 8. Data of Birth (Month, Day, Year) JAN. 5, 1951 If Undar 1 Yaar if Undar 24 Hrs. Hours Min. 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** Days % M 2□ F BALTIMORE, MD 46 220-50-1011 Yrs Director Usual Rasidance of Decedant with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show trsumetic event, the Medical Examinar must be notified at BALTIMORE XX Yas 2 No MD n/a Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country?
UNITED STATES ST. APT.6H 21202 26 S. EXETER permit. Peges 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 234 any Injury or other traumatic event, it a Medical Event and Injury or other traumatic event, it is Medical Event and Injury or other traumatic event. Funerai 12. Was Decedant Evar in U,S. Armed Forcas? 14. Race - Amarican Indian, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☑ Yas 2 ☐ No If Yes, Giva Yaar or Datas: 1 ☑ Nevar Married 2 Married Saltimore, Maryland 21215-0020 1 Yas 2X No BLACK Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Spacify only highast grada complated) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) JONES TOWN-DAYCARE ENGINEER 12 th MAINTENANCE-17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maldan Sumama) PANSEAL NEWBORN JAMES CARMON 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) BROADWAY, BALTIMORE, MD 21213 PANSEAL CARMON 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 3-22 BALTIMORE, MD BALTIMORE CEMETERY 21. Signatura of Funaral Sarvice Licenses 22. Nama and Addrass of Facility AVVE FH.-1101 E. NORTH WM. C. MARCH Karen m 23a. Pentl. Entar the disaesa, or complications that dused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata intarval Batwaan Onset and Death **Physician** /Medical immediete Causa (Final disaasa or condition rasulting in daath) Pneumonia Examiner Due to (or es e consequance of) Examiner physician and the burial-transit that the death certificate be axecuted Sequentielly list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated avants rasulting in daath) Last Due to (or es e consequence of): P.O. Box 68760, Physician/Medicai Dua to (or as a consequance of): attending p signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown ords. P 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performad? Completed 2 No Be 25. Was case rafarred to medical exeminar? 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Nasidence 8 Othar (Specify) 0 Yas 2□ No Division of Attending Phy Certification: 27. Mannar of Deeth 28a. Deta of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury et Work? 1 Netural To the Hospital or Attending within 24 hours after death. To the Funeral Director: An completely filled in by the fun 1 Yas 2 No 2 Accidant 6 Could not be determined 3 ☐ Suicida 28a. Place of injury - At homa, farm, straet, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicida 29a. Certifian 1 Cartifying Physician: To tha best of my knowledge, deeth occurred at the tima, date end place, and dua to tha causa(s) and mannar as stated. Medical Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of cartifiar 29c. Licansa numbar 29d. Data signed (Month, Day, Year) O.C.M.E MARCH 15, 1997 30. Nama and addrass of person who completed cause of death (itam 23a) (Type, Print) THEODORE Miking 111 Penn Street, Baltimore, Maryland 21201 31. Data filad (Month, Day, Yaar) 32. Ragistrar's Signatura State MAR 1 9 1997 Registrar



		1 Decedent's Name (First Attitute	State of Ma	arylanu /		rificate of			Reg. No.	97	08478
Physic /Med		Decedent's Name (First, Middle, Last CECELIA	NOVAK					2. Date of D Month 2	Day	Year 7	3. Time of Death 1:35
Exami		4e. Facility Name (If not institution, give DEATON NURSING					4b. City, Town, BALTIM	or Location of Des	th 4c. Coun	ty of Death	
Funera Director		5. Social Security Number 6. Se 220-07-4952		e (In yrs. last b	oirthday)_ Yrs.	If Under 1 Yea Months Day	r If Under 24 l			9 Birthol	ece (State or Foreign
the Marylend 28a-f show	tor	Usual Residence of Decedent 10a. Stete 10b. County MARYLAND N/	А	10c. City, To						10	Od. Inside City Limits
with the	Director	10e. Street and Number 1300 S. ELLWOOD	AVENUE			10f. Zip Code	224		10g. Citizen o		ry?
be filed within 72 hours after death with the Marylend tiel Hygiene. d other than "naturel", or items 23s or 28s-f show event, the Marital Evantive must be notified at	by Funeral		12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		If '	as Decedent of	Hispanic Origin? ban, Mexicen, Pu	(Specify Yes or N lerto Rican, etc.)	lo- 14. Ri	ace - America ack, White, e	
be filed within 72 hours aft itel Hygiene. d other than "naturel", or event, the Medical Even	Completed	15. Decedent's Edu (Specify only highest grad Elementery/Secondery (0-12)	ucation 16e. C de completed) (i		Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired) SEAMSTRESS			working	16b. KInd of Bu		
	To Be C	P AUGUSTINE NOVAK LO						Name (First, Middle E PASEL	e, Maiden Suma	ame)	
1 end Health Im 27		19a. Informant's Name/Relationship (T) MR. RONALD STAC 20a. Method of Disposition		1	2704			Rural Route Num.	CLEAR	SPRIN	VG, MD.
Peges nent of int: If it iry or o		1 Surlal 2 Cremation 3 F 4 Donation 5 Other (Specify)	\$2-20	-20 balto. CO. MD.							
Demit. Departr Importa any lok		August The Service Livers	Czarou	wki	/ 120	1 DUNI	DALK AV	IERAL HO	ALTO. N		1222
Physician /Medical Examiner		23a. Part. Enter the disease, or complete hook, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)	a. ALZH		's Di	SEASE		ade or respiratory	arrest,	-	Approximate Interval Between Onset end Death
be executed sician end buriel-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	b	Due to (or as e	onseque	ence of):					
death certificate be executed e ettending physician end ad for use es the buriet-transit	/Medical	Ceuse (Diseese or Injury that initiated events resulting in death) Lest	c. Due to (or as e consequence of):							1	
the the	Physician/M	Part II. Other algnificant conditions cor		d tobacco usa d		the cause of death?					
v requires that been signed b should be deta	by	PRESSURE LICCO	ER ON SI	ACRUM RI T.F	DIN	IG		24e. Wa	s en eutopsy	24b. We	re autopsy tindings
The law ate hes b page 2 s	Completed		12.010	pear		9.		1	Yes 2⊠No	of d	npletion of ceuse feath?
Physic this ce	n: To Be	27. Mapner of Death	lospital: 1 Inpatie	y 28b.	Outpatient Time of	3□ DOA C	ther: 4 Nursin	Deeth (Check only g Home 5 Res 28d. Describe)
or Attending I efter death. Director: After I in by the funer	Certification:	1 🖺 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	N/A 28e. Plece of Injubuilding, etc.	ıry - At home,		M 1	Yes 2 No		(Street and Nur own, State)	n <i>ber or R</i> ural	Route Number,
To the Hospital or within 24 hours effer To the Funeral Direction of the Completely filled in the Completely filled in the complete of the com	edical Ce	29a. Certifier (Check only one) 1 Certifying Physical Certification Physical Certificat	alclan: To the best oner: On the basis of and manner ste	examination a	ge, death o	occurred at the estigation, in my	time, date end pt opinion, deeth o	ace, end due to the	e cause(s) end r e, date end place	manner as sta	ated. the ceuse(s)
within within To the	Me	29b. Signature any little of certifier	100)		29c. Lice	rse number		29d. Date sign	197	Jay, Year)
6		GEORGE INCER,	M.D. 6/	eath (Item 23a)	(Type, Pr	rint) S ST.	BALTON	IORE, MI). 212	30	
St Regist	ate rar	31. Dete filed (Month, Day, Year) MAR 1 9 199	7 32. Registra	r's Signature	-Aand	Lecc					

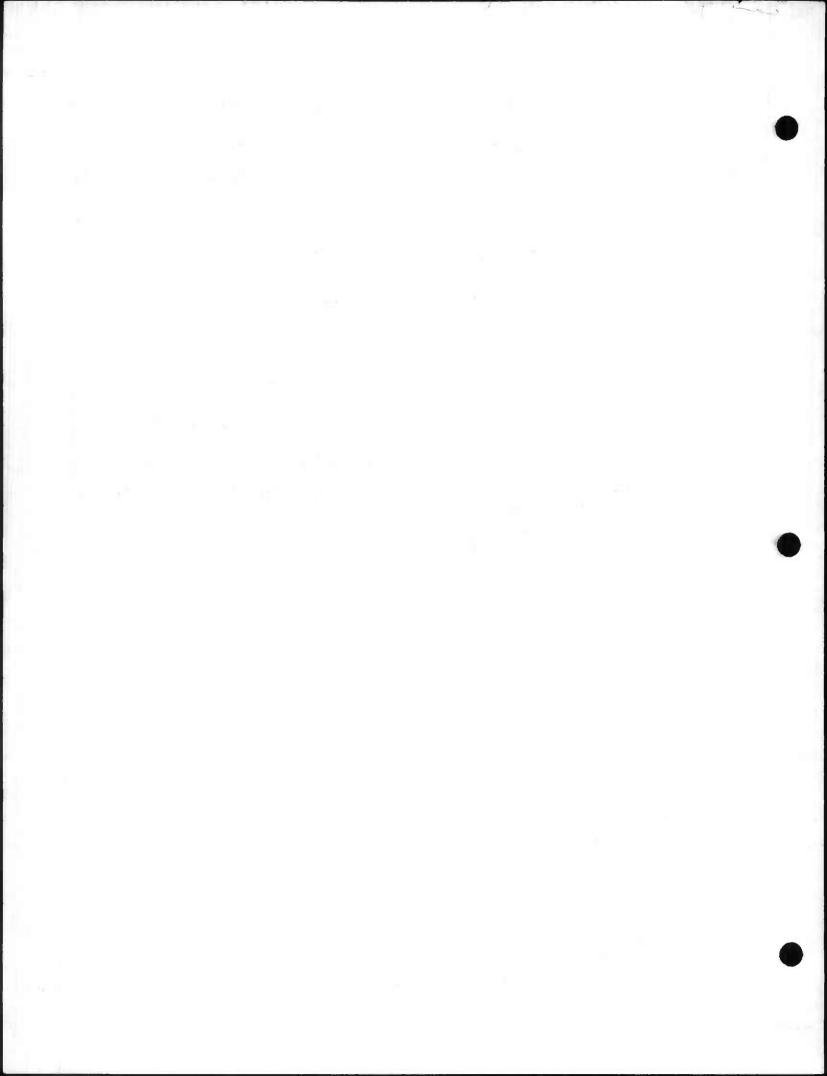
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State of Maryland / Department of Health and Mental Hygiene

	It	tems: 23 part I,27 per		/10/97 reb	Certificate o	f Death		g. No.	91	084/5
Physic	ian	Decedent's Nema (First, Middla, I					2. Dete of Deetl Month	Day	Yeer	3. Tim U th
/Med	ical	NIJULE	М.		PAR		MARCH			3:00P.M.
Exami	ner	4e. Facility Name (If not institution, good Security Number 6	HOSPITA		hdev) If Under 1 Yas	4b. City, Town, or L BALTIM If Under 24 Hrs.		4c. County	n/a	None (Ctate or Fernis
Funeral Director		none Usuel Residence of Decedent	10 M 2□ F		rs. Months Dey		FEB. 8,	1997	9. Birthp Coun M A	eleca (State or Foreigntry) RYLAND
the Maryland 28a-f show	ctor	10e. Stete 10b. County	/ a	10c. City, Town	or Location BALTIMOR	E			1	Od. Inside City Limits
oth with the 23a or 28	al Director	10e. Street end Number 130 N. ROSE	STREET		10f. Zip Code	21205	10g. Citizen of What UNITED			
urs after dee al', or items	by Funeral	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedant Armed Forcas? 1 Yes, Give Year or Datas:		13. Was Decedent of If Yas, specify Cu			14. Red	a - Amaric ck, White,	an Indian,
s 1 and 2 should be filed within 72 hours af f Haalth end Mental Hygiene. Item 27 is marked other than "natural", or other trsumetic event, in Medical Exam	Completed	15. Decedent's (Specify only highest of Elamentary/Secondery (0-12)		5+)	16e. Decedent's Usuel Occupe (Give kind of work done of life. DO NOT use retired		sing	16b. Kind of Business/Indus		dustry
2 should be filed withing end Mental Hygiene. Is marked other than sumatic event, he M	To Be Co	17. Fefhar's Name (First, Middle, La	K E R		DAD!	18. Mother's Nam	e (First, Middle, M Z Y S M		n/a na)	
1 and 2 should be file Haalth end Mental Hy, em 27 is marked othe other trsumatic event,		19e. Informant's Name/Relationship PAMZY S	(Type, Print) MITH		Meiling Address (Stre 130 NOR		ST., B			,
Page nent o int: If iry or		20e. Method of Disposition 1 □ Burlel 2X□Cremetion 3 4 □ Donetion 5 □ Other (Spec	cify)	cemetery	Disposition (Neme of c, crametory or other p	(ece)	3 – 2 0	BALT		
permit. Pag Department Important: It any injury o		21. Signature of Funeral Service Llo	ensee		WM. C. I	ress of Facility MARCH FH	1101	E. N	ORTH	AVENUE
Physician /Medical Examiner	Examiner	23e. Pen1. Enter the disease, or conchock, or heart feilure. List on Immediate Cause (Finel disease or condition resulting in deeth)	SUDDEN IN	NFANT DEAT	H SYNDROME onsequenca of):	ying, such es cardiec	or raspiratory arra	Sī,		Approximate Intervel Betwaen Onset and Deeth
ertificate be executed ding physician and se as the burial-transit	Medical Exar	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in daeth) Lest	c	Due to (or es e c						
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hat the de	by Physician	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute 1 Yes 2 No 3 Pr								
ne law requires that the a hes been signed by th age 2 should be deteche	Completed b						24a. Wes er perform	eutopsy led?	ev	are eutopsy findings allable prior to mpletion of causa deeth?
The I	Be Cor	25. Was case refarred to medicel exeminer?				26. Plece of Dee	1 XYe		15	XYas 2□ No
1/19	2	1X Yes 2 No	Hospitel: 1 ☐ Inpatie		petient 3LI DOA		ome 5 Reside	nce 6 DOth	er (Specif	y)
Attending P ar death ector: After by the funer	Certification:	27. Manner of Deeth X \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	he		jury W	Yes 2□No	28d. Describe ho			
Mal or Attending urs after death ral Director: Afte illed in by the fune		4 Homicide determine		ury - At home, far c. <i>(Specify)</i>	m, street, factory, offic	8	28f. Location (Str City or Town,	eet end Numb , Stete)	oer or Rura	ii Houte Number,
To the Hospital or / within 24 hours after To the Funeral Dire complately filled in t	ledical	(Check only one) 217 Medical Exu	Physicien: To the best of aminer: On the basis of end menner ste	exemination and	deeth occurred of the /or Investigation, in my	time, dete end plece, oplnion, deeth occur	end due to the ce red et the time, de	use(s) end me te end place,	enner es si and due to	teted. the cause(s)
To the within 2 To the comple	Σ	29b. Signature and title of certifier Onald	& Wrigh	+ MD	0.0	C.M.E.		d. Date signe		
)		30. Nema and eddress of person who DONALD Gr. [2] 31. Data filed (Month, Dey, Year)	URIGHTA	10	Type, Print) 11 Penn	Street, 1	Baltimo	re, M	aryl	and 2120
Sta Regist		MAR 1 9 199		Devidson-A	ndelle					

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** John Month 3.30 PM Karen /Medical 4a. Facility Neme (If not institution, giva straet end numbar) 4b. City. Town, or Location of Deeth 4c. County of Daath **Examiner** SECOUR BON HOSPITAL BALTIMORE n/a 5. Sociel Security Number If Under 1 Yaar If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (Steta or Foreign Country)
 CAROLINA **Funeral** 1 ₹ 1 2 □ F Deys 241-32-0501 Yrs. 67 AUG .16,1929 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 20-4. Any injury or other traumatic event, the Maryland 2000. 10b. County 10c. City. Town or Location 10d. Inside City Limits **Funeral Director** MD n/a BALTIMORE 1 1 No 10f. Zip Code 21239 10e. Street and Number 1652 E. 10g. Citizen of What Country? BELVEDERE AVE UNITED STATES 12. Wes Decedent Ever in U,S. Armed Forcas? X□XYes 2 □ No It Yes, Give 11. Meritel Stetus Was Decedent of Hispanic Orlgin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Ricen, etc.) Race - Amaricen Indian Bleck, White, etc. 1 Never Married 2/ Married 1 ☐ Yes 2 √ No Specify: Completed by Specify: 3 Widowed 4 Divorced BLACK Yaer or Detes: 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4 or 5+) 11 th STEEL WORKER BETHLEHEM STEEL 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumeme) Be ERNEST PHILLIPS ANNIE 2 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code, MATTIE PHILLIPS 1652 Ε. BELVEDERE AV, BALTIMORE, MD# 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Surial 2 □ Cremation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) PARK 3 - 21RANDALLSTOWN, MD KING MEMORIAL 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility WM. C. MARCH FH.-1101 E. NORTHA VE Karen 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximate tntarval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner e law requires that the death certificete be executed the burial-transit and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that believed as each of the cause of th Due to (or es a consequence of): Records, P.O. Box 68760 igned by the attanding physician be datached for use as the buris Physician/Medical that initieted events resulting in death) Lest Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Wara autopsy tindings eveilebla prior to completion of ceusa of deeth? Completed 24a. Wes en autopsy peeu has 1 ☐ Yes 2 ☑No 1 Yes 2 No Certification: To Be 25. Wes cese referred to medical 28. Plece of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 ★ npatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2N No 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending Investigation death. 1 ☐ Yes 2 - No 2 Accident d or Atten-after deal Director: 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) à 4 Homlcide To the Hospital of within 24 hours at To the Funeral D completally Illiad in 10 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the cause(s) end menner stated. Medical 29e. Certifier (Check only 29d. Date signed (Month, Dey Year) 29b. Signeture end title of certitier 29c. License number

14

Registrar

DHMH 16 Rev 6/95

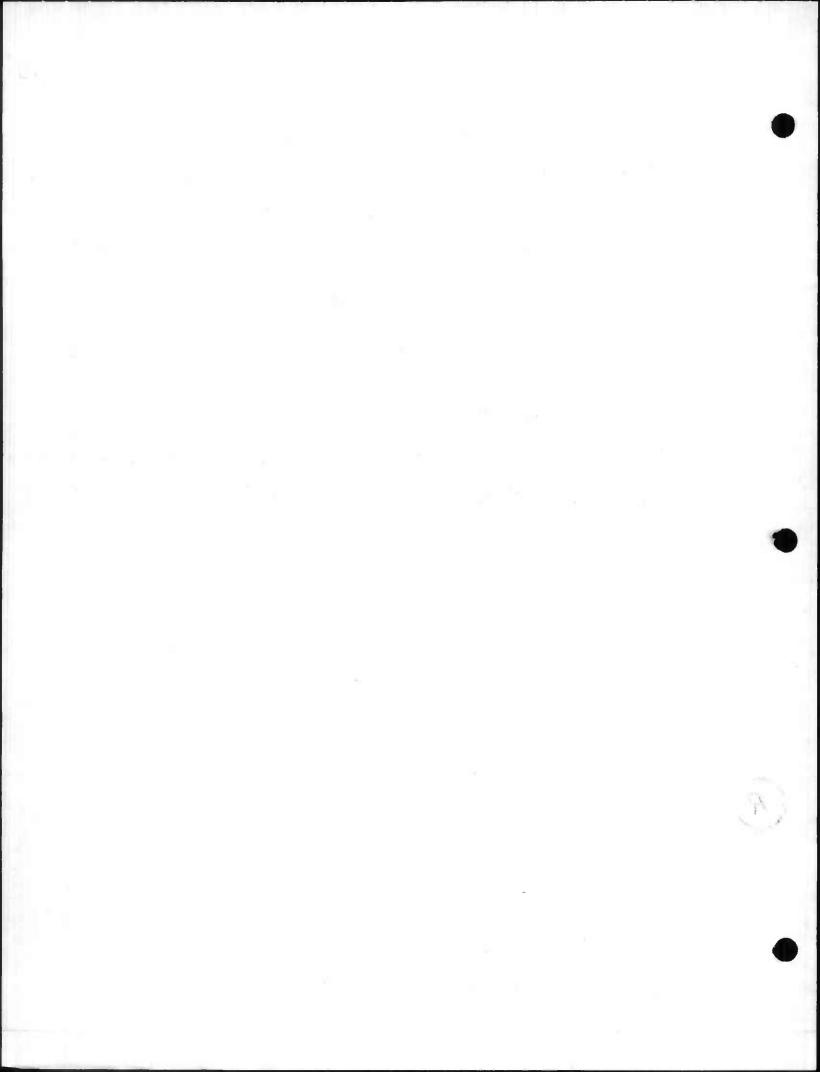
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31. Deterfiled (Month, Day, Year)

MAR19

30. Neme and eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

Registrer's Signeture



Please Type or Print in Black indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant'a Nama (First, Middla, Last) 2. Data of Death Day **Physician** Yaar Elizabeth C. Price March 17, 1997 /Medical 4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Atlantic General Hospital Berlin Worcester If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Sacurity Number Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 √F Yrs. Director 216-16-9237 Usuai Rasidance of Decedan July 15, 1922 England the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exampler must be notived at Berlin 1 Yes 2 No Maryland Director Worcester 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21811 United States 79 Newport Drive Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas ② No If Yas, Givé Yaar or Datas: 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - Amaricen Indian, Biack, Whita, atc. 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: ğ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usuai Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Busineas/Industry permit. Peges 1 and 2 should be filed within 7. Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medit 200.6. Elamentary/Secondary (0-12) Collega (1-4or 5+) Publication 12 Years Office Manager 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be Elizabeth Pue Henry W. Clark 19a. Intormant's Name/Ralationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 1484 Westcliff Drive Pasadena, MD 21122 Pamela P. Burke/Daughter 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 € Burial 2 Cramation 3 Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Moreland Memorial Pk Cem. 3/19/97 Parkville, MD 21. Signature of Funarai Sarvice Licensee 22. Nama and Addrass of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Pert1. Enter the disaasa, or complications that ceused the death. Do not antar the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximeta Intarval Between Onset and Deeth **Physician** /Medical Immediata Causa (Final Gestion tistinal bleeding disaesa or condition rasulting in daath) **Examiner** Due to (or es a consequance ot) arrhoses and I-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in daeth) Last Dua to (or as a consequance of) physician s the buriel P.O. Box 68760. Physician/Medical Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? signed by t Obstructive pulmoning dueone 1 Yes 2 No 3 Probably 4 Onknown Records, p 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to complation of causa of death? Be Completed 1 Yes 2 1 No 1 Yas 2 No 25. Was cesa ratarred to medical axaminer? 28. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Yas 2 No 27. Manner of Death 28c. Injury at Work? Certification: 28b. Tima of 28d. Dascribe how injury occurred Attending 5 Pending invastigation 1 Netural urs affer dea.

Vi Director: A.

Yi by P. 1 Yas 2 No 2 Accident 3 Sulcida 6 Could not be datarminad 28t. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 T Homleida To the Hospital o within 24 hours at To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

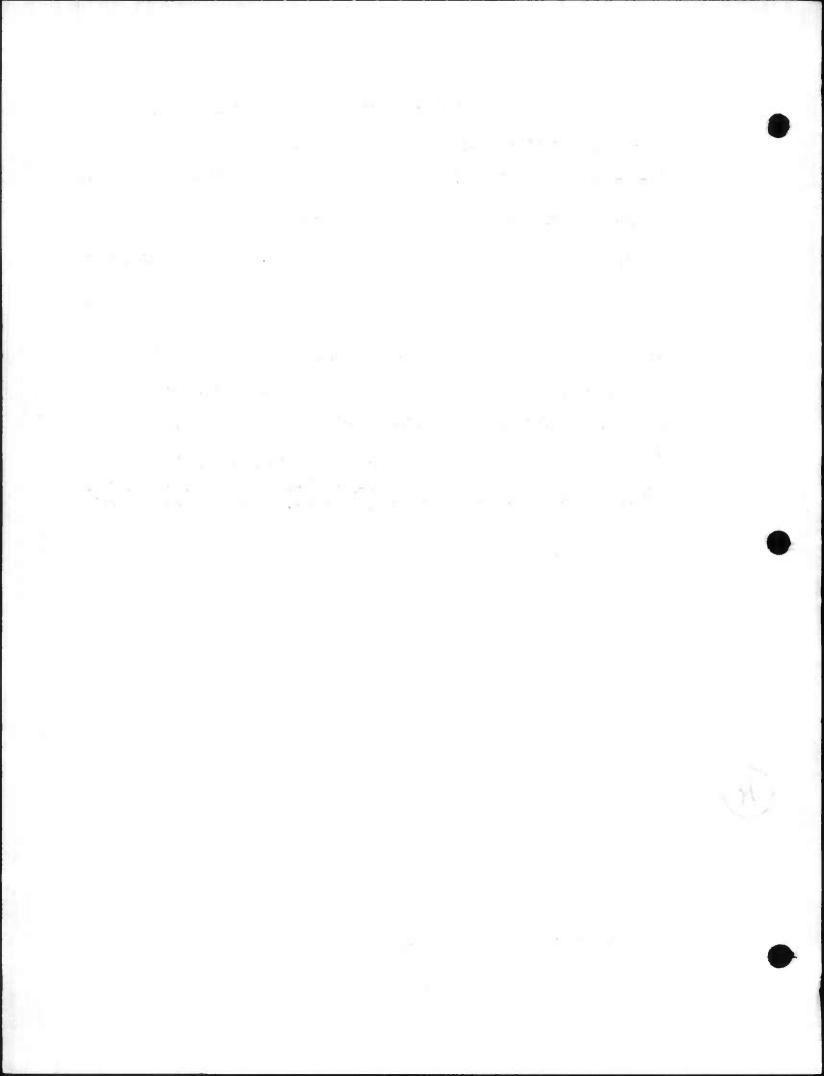
2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the causa(s) and manner stated. 29a, Cartifiar edical (Check only one) 29b. Signature and title of certifier physician H44283 Herthary Drive Bester, no 30. Name and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print)

Robert Dorlo (277) (277) (277)

32. Registrar's Signature

DHMH 16 Ray 6/95

State Registrar 31. Data filed (Month, Day, Year) MAR 1 9 1997



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Veer March Gail L. Peterson 171997 5:05 ans /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** If Under 24 Hrs. 8. Dete of Birth Hours Min. 0607227 1921 Carecenter Charlestown Baltimore 6. Sex 1 M 2 □ F If Under 1 Year 9. Birthplece (State or Foreign PA 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys 204-10-2786 75 Yrs. Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notified at 10d. Inside City Limits MD Baltimore 1 ☐ Yes ŽŪNo Director Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 713 Maiden Choice Lane #2315 21228 U.S.A. death 12. Wes Decadent Ever In U,S Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Heelin and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or item any injury or other treatment over the Mandale. 1 Never Merried 2 Married 1 X Yes 2 □ No If Yes, Give Yeer or Dates: White 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Specialist 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Personnel Security Dept. of Army 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Theodore Peterson Mattie L. Trask 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21228
713 Maiden Choice Lane #2315 Catonsville, MD Loretta Peterson/ Wife 20b. Place of Disposition (Neme of cemetery, crematory or other placa) Cem. 3/20/97 Dundalk, MD. 20e. Method of Disposition t Buriel 2 ☐ Cremetion 3 ☐ Removel from State Sacred Heart of Jesus 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatelle of Funger Backice Ligensee Sterling Ashton Funeral Home, 736 Edmondson Ave.Balto., MD. 13. Enter the disease, or conflications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final End Stage Congestive heart Failure
Due to (or es e consequence of): disease or condition Examiner Due to (or esp consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and P.O. Box 68760, physician Physician/Medical ã Due to (or es a consequenca of): Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Chronic Renal Failure ecords. þ 24b. Were autopsy findings evelleble prior to completion of cause of death? Completed 24a. Was en eutopsy performed? Diabetes Mellity 2 No 1 Yes 2 No 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To Division of 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menger of Deeth 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Neturel al or Attending safter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) D51051 Andres Salazar 7/1 Majden Choice Lane, Catonsville, MD, 21228

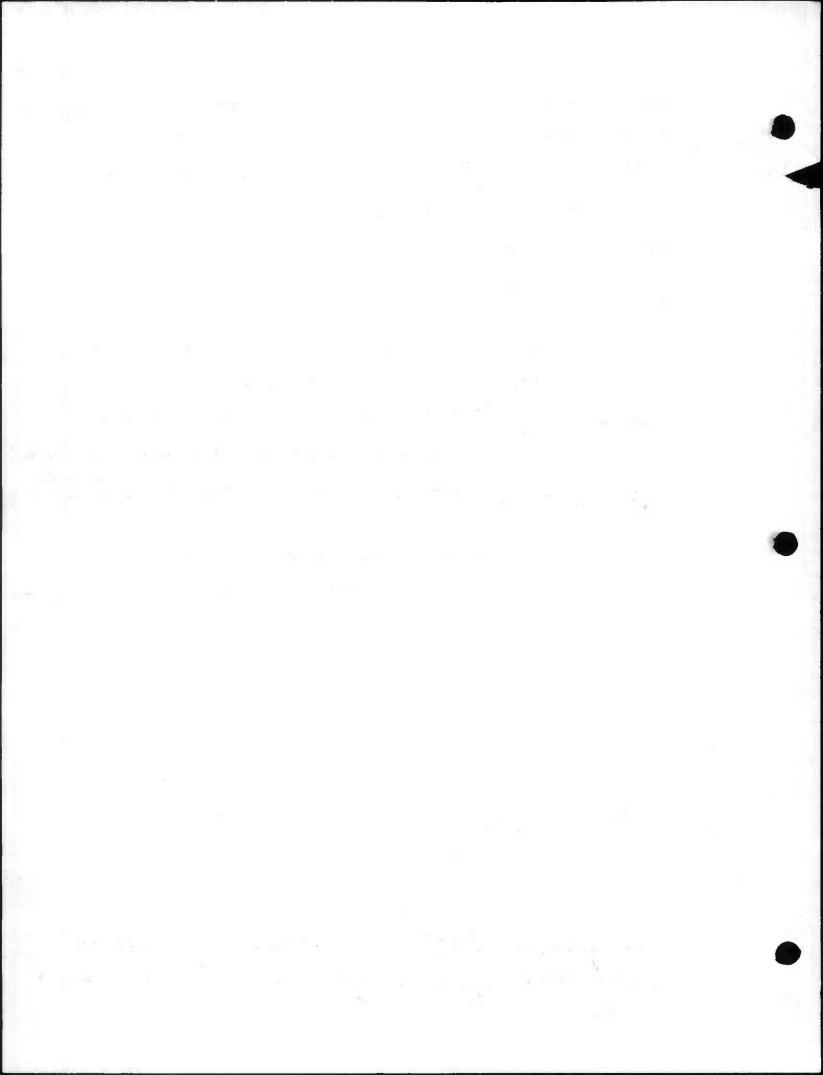
31. Dete filed (Month, Day, Year)

MAR 19 1997

Compared Sand See State Registrar

	1. Decedent's Name (First, Middle, Last)	2. Dete of Dee		3. Time of Death
Physician /Medical	Caleb E. Queen Jr.	March	15°,199	
Examiner	4a. Facility Name (If not institution, give street and number) 42.06 Penhurst Avenue 4b. City, Town, or Le Baltimor		N/A	of Deeth
Funeral Director	5. Social Security Number 213-09-7474 6. Sex 12 F 86 Yrs. lest birthday) 15 Under 1 Year 16 Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day July I	8,1910	9. Birthplace (State or Foreign Country) D. C.
MO TO	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
or 28a-f ehow se nutitied at Director	Md. N/A Baltimore			1 Yes 2 No
r itams 23s or 25s-fe direct must be notified Funeral Director	10e. Street and Number 4206 Penhurst Avenue		U.S.A.	/hat Country?
by By	11. Maritef Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes, Give Year or Dates: 12/1945 13. Was Decedent of Hispanic Origin? (Sp. if Yes, specify Cuban, Mexican, Puerto 1 □ Yes, Give 1 □ Yes 2 □ No Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	a - American Indian, k, White, etc. Black
ygiana. ner than "natura nt, the Medical I	15. Decadent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+)	ing	16b. Kind of Bu	siness/industry
Com	1+ Claims Examiner			overnment
marked other than imatic avent, the M To Be Comp	17. Fether's Neme (First, Middle, Lest) Caleb E. Queen SR. 18. Mother's Name Ida Nel		Malden Surneme	9)
	19a. informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street end Number or Run Kay — UHughes 3040 Essex Road Bal	al Route Numbe timore	r, City or Town, S	Stete, Zip Code) 21207
Important: If Item 27 any injury or other to once.	20a. Method of Disposition 1			city or Town, State re County, MI
Important: If It any Injury or o	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Nu 2501 Gwynns Fall			
132	23a. Pert1. Et let the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on eech line.	or respiratory en	rest,	Approximate Intervel Between
ysician /ledical	Immediate Cause (Finel disease or condition CONGESTIVE HEART I	=AiLV	Re	Onset and Death
aminer	Due to (or es a consequence of):		,,,	
in and ial-transit Examiner	Sequentielly list conditions. Due to (or as e consequence of):	0315		one year
	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury			
0 0	that intilated events resulting in death) Last Due to (or as e consequence of):			
d for usa as	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Oak Did o		tribute to the cause of death?
igned by the attending be datached for use a by Physician/M	Part II. Other significant continuous continuoung to death but not resulting in the underlying cause given in Part I.	1 N		3 Probably 4 Unknow
2 should		24a. Was e perfor	en eutopsy med?	24b. Were eutopsy findings available prior to completion of cause of death?
cartificata haractor, paga		1□ Y	es 200 No	1 ☐ Yes 2 ☐ No
0 0	25. Wes case referred to medical examiner? 1 Yes 2 No No	me 5 Resid		or (Specify)
	27. Manner of Death 1 Natural 5 Pending 28a. Dete of Injury (Month, Dey Yeer) 28b. Time of Injury Work? Work?		ow injury occurre	
ctor: yy tha	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)	28f. Location (S City or Tow		er or Rural Route Number,
To the Funeral Dirac complataly filled in t	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	and due to the c	ause(s) and mar lete and piece, e	nner as stated. nd due to the ceuse(s)
To the	29b. Signature and title of certifler.	2	29d. Date signed	(Month, Dey, Year)
	30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)	1-	3/	18/7/
01-1-	MIGUEL KARACUSCHANSKY M.D. 300E.	33nd S	T BAL	TO_ 21218
State Registrar	31. Date filed (Month, Dey, Year) 32. Res files S. Supplement 19 1997			

Registrar DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

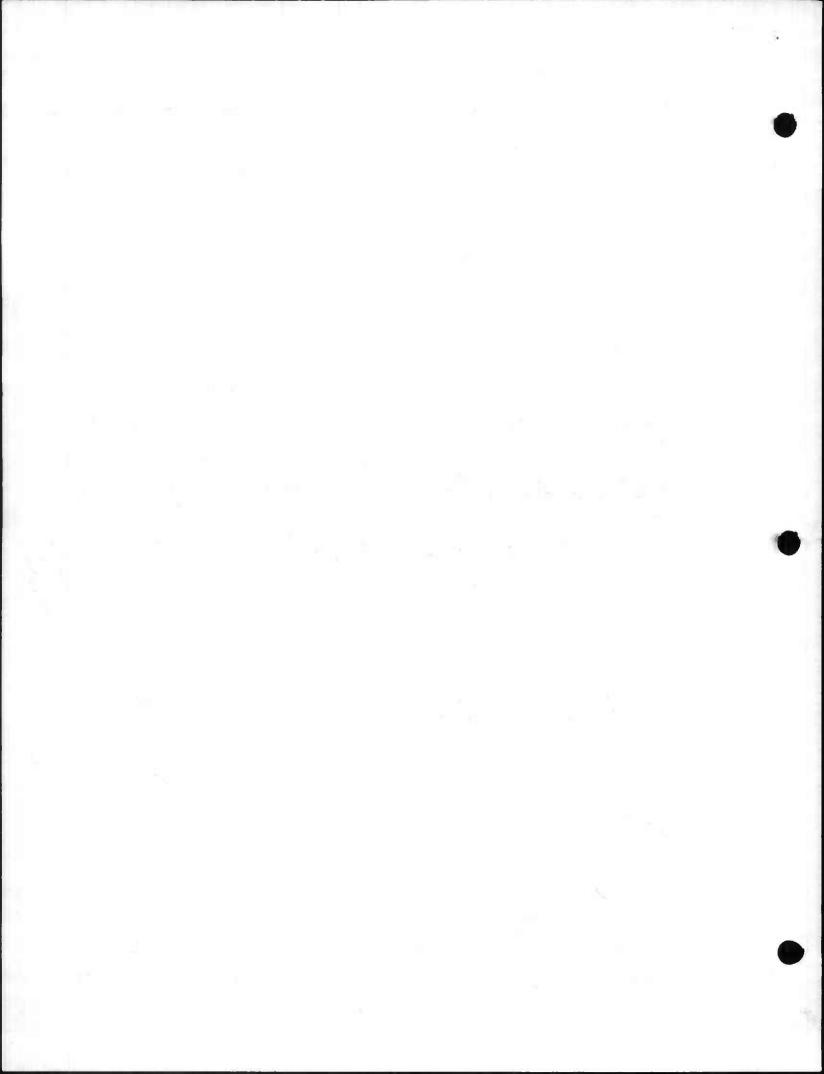
			State of N	raryian			of Death	,	giene Reg. No.	97	08484				
Physic /Med		1. Decedent's Name (First, Middle, L	L. ()) v u	de				ch Day 4	Year 1997	3. Time of Death				
Exami	ner	4a. Facility Name (If not institution, g					4b. City, Town,	or Location of Deatl	4c. Cou	nty of Death					
	111 1	ST. ELIZABETH'S					BALTI			N/A					
Funeral Director		5. Social Security Number 6. 219-16-3432 Usual Residence of Decedent	Sex 7. A 1 M 2 M F	ge (In yrs. 84	(ast birthday) Yrs.	If Under 1 Y Months Di		Irs. 8. Date of Bir (Month, Da APRIL 6	th ly, Year) ,1912		place (State or Foreign http:/ RYLAND				
yland		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits				
sth with the Marylar 23a or 28a-f show	ctor	MD BALT	IMORE		MO	NKTON					1☐Yes 2☐No				
th the	Sire.	10e. Street and Number				10f. Zip Co	de		10g. Citizen	of What Cou	ntry?				
23a	10	17044 WESLEY CHAI	PEL ROAD			211	11-1209		U.S.A.						
72 hours after death with the Maryland "natural", or items 23a or 28a-f show pojest Examines man be not feet	by Funeral Director	Marital Status Naver Married 2 Married Married 2 Married Married 4 Divorced	12. Was Decedan Armed Forces 1 Yes 2 1 If Yes, Give Yaar or Dates:	? No		Vas Dacedent Yes, specify (of Hispanic Origin? Cuban, Mexicen, Pu No <i>Specify:</i>	(Specify Yas or No erto Rican, atc.)	- 14. F B Spe	Race - America Black, White, Incify:					
72 hou		15. Decedent's	Educetion		16a. Deced	ent's Usual O	cupation		16b. Kind of	ind of Business/Industry					
s 1 and 2 should be filed within 72 hours af f Health and Mental Hyglene. Item 27 is marked other than "natural", or other traumatic event, the Medical Exam	Completed	(Specify only highast g Elementary/Secondary (0-12) 6TH GRADE	College (1-4or	5+)		kind of work de DO NOT use re AMSTRES	one during most of vitired)	working		CLOTHI	ING				
d 2 should be file th and Mental Hy 7 is marked oth traumatic event	Be	17. Father's Name (First, Middle, Las	t)				18. Mother's N	lame (First, Middle	, Maidan Sum	nama)					
Men Men	2	WILLIAM BOONE					-	AH LOUISE							
d 2 she th and 7 is me traum		19a. Informant's Name/Relationship WILLIAM QUADE, JR		ueu)		-	reet and Number or								
ges 1 and t of Health If item 27 or other tr		20a. Method of Disposition	GRAND NET	20b. P	Place of Disposemetery, crem	sition (Name o	Y CHAPEL	ROAD-MON Date	20c. Locetio		11-1209 own State				
80 = 5		1 St Burial 2 □ Cramation 3 4 □ Donation 5 □ Other (Spec		,											
permit. Pa Departmen Important: eny injury once.			VILLE												
permit. Departrimporta		22. Name and Address of Facility HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229													
		23a Party. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrest, in lock, or heart fallure. List only one cause on each line.													
Physician /Medicai Examiner	ŀ	Immediate Cause (Final disease or condition resulting in death)	a. Cerch		i i	٨	ident			1	Interval Between Onset and Death				
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uted	Examiner	Sequentially list conditions. Due to (or as a consequence of)								1	10 422				
ificate be executed g physician and as the bural-transit											,				
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E 00 66	_	resulting in death) Last	i												
eath cert attendin for use	lan/		d							1					
the al	Physician/N	Part II. Other algnificant conditions	contributing to death I	but not resi	ulting In the ur	derlying cause	givan In Part I.	23b. Did	tobacco use	contribute to	o the cause of death?				
that the death cer ed by the attendin detached for use								10	Yes 208 No	o 3□ Pro	bably 4 Unknow				
w requires that the death center is signed by the attending to the attending to the attending to the strength of the second to t	Completed by							24a. Was	an autopsy med?	av	fere autopsy findings rallabla prior to impletion of ceusa death?				
10	\E							101	Yes 2 No		Yes 2 No				
LI	0	25. Was cese referred to medical					26. Place of C	Peath (Check only o		, , ,					
2	To B	examiner?	Hospital: 1 Inpat	ient 2 🗆	ER/Outpatien	3□ DOA	Other:	Home 5 ☐ Rasi		Other (Specif	(v)				
Ing Phys h. After this funeral di		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inj (Month, Di	ury av Year)	28b. Time of Injury	28c.	njury at Work?	28d. Describe							
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not determine	be 28e. Place of In		ome, farm, stre	М	1 ☐ Yes 2 ☐ No	28f. Location (mber or Rure	al Route Number,				
To the Hospital or Attending Physici within 24 hours after death. To the Funeral Director: After this smill completely filled in by the funeral directors.		29a. Certifier 1 Certifying P	hyaician: To the best	of my kno	wledge, death	occurred at th	e time, date and pla	ice, and due to the	cause(s) and	manner as s	stated,				
he Ho in 24 he Fu	Medical	(Check only one) 2 Medical Exa	miner: On the basis of and manner si	of examinal	tion and/or inv	estigation, in n	ny opinion, death oc	ccurred at the time,	date and plac	e, and due to	o the cause(s)				
To the to the to the to	Σ	29b. Signature and title of certifiar				29c. Lic	ense number		29d. Date sig	ned (Month,	Day, Year)				
6		30. Name and address of person with	o cappleted cause of	death (Item	23a) (Tvne I	Print)	3562	6	March	14	1997				
り		Keyinn	AMer	1-/	3	151	Benson	Ave the	lt M	0 2	1127				
St: Regist	ate rar	31. Date filed (Month, Day, Year) MAR 1 9 100		race Signa	on-Rand	102									

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 0.7

						Cert	ificate of	f Death		Reg. No.	1	00400		
			1. Decedent's Neme (First, Middl	, Last)					2. Dete of De	elh		3. Time of Death		
Į.	Physic		ERIC SAMUEL R	ZZO JR					Month MAR	Dey 16 1	Year 1997	1605 pm		
	/Medi Exami		4a. Fecility Neme (If not institution	, give street and no	umber)			4b. City, Town, or L						
	EXCITI		NATIONAL NAVAL	MEDICAL.	CENTER.	BETHESI	OA MD	BETHESDA		MONTO	OMER	Y CO		
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Yee	r If Under 24 Hrs.	8. Dete of Bir	th				
	Director	Г	N/A Usuel Residence of Decedent	XX M 2□ F		Yrs.	Months Deys	s Hours Min.	(Month, De Mar. 16	y, Year)		plece (Stete or Foreign intry) yland		
	fand		10a. Stete 10b. County		10c. City	y, Town or Loca	ition				T	10d. inside City Limits		
	Mary	ō	MD Prin			77						1 ☐ Yes 2X No		
	the 128	Director	10e. Street end Number	ce Georg	e	Hyatts	7111e 10f. Zip Code	2		10g. Citizen of	What Cou	into/2		
	With Man	ō	6716 Chillum N	(an an D-a	1		· ·				vinet cou	vidy r		
	eath	era	11. Meritel Status		cedent Ever in U,	S 12 W/	2078		noity Vac or No	USA	o - Amori	ican indien,		
21215-0020	within 72 hours after death with the Maryland ene. then "natural", or items 23s or 28s-f show he Madical Examiner must be notified at	by Funeral	1 X Never Merried 2 ☐ Merri 3 ☐ Widowed 4 ☐ Divorced	Armed F	orces? 2 X No ive	14)	Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	Rican, etc.)	Bla Specif	ck, White			
5-0	n 72 hours natural',	Completed	15. Deceden	's Education		16a. Decede	nt's Usuel Occi	upation		16b. Kind of B	usiness/ir	ndustry		
21	s 1 and 2 should be filed within 72 hr f Health and Mentel Hygiene. "netur them 27 is marked other than "netur other traumatic event, the Madical	pie	(Specify only higher Elementery/Secondery (0-12)	T	(1-4or 5+)	lifa. DC	na or work aon O NOT use retir	e during most of work red)	king					
2	filed withir Hygiene. rither then	0	Ø	Ø		Infa	int			N/A				
P	offied officer	Be	17. Fether's Neme (First, Middle,	Last)				18. Mother's Nem	e (First, Middle,					
Maryland	12 should be filed n end Mentel Hygi is marked other raumatic event,	To	Eric Samuel Ri	zzo, Sr.				Marybell	LSoto					
ary	should by the		19e. Informant's Name/Reletions	nip (Type, Print)		19b. Melling	Address (Stree	et and Number or Ru		er, City or Town	Stata, Zi	p Code)		
	end 2 salth e n 27 is		Eric Rizzo, Sr	. /Father	r	6716	Chill:	um Manor H	Road. Hy	attevil	10	MD 20783		
a,	of Health I Nem 27 I	-	20a. Method of Disposition	,	20b. P	lace of Disposit	ion (Neme of		Dete	20c. Location				
Baltlmore,	Pages nent of h int: If its ury or of		1 Burial 2 Cremetion		Stete	emetery, creme		,	2/10					
프	rtani njun		4 Donetion 5 Other (S		Dal			gton Cr.	3/18	Laurel	, Ma	ryland		
Ba	permit. Pages Department of Important: If i any Injury or once.		Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, MD 20707											
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а	Physician		Onset en											
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o.	that the de ed by the detached	Physician/	Pert II. Other significant condition	ns contributing to d	leath but not rasu	uiting In the und	arlying ceuse g	iven in Pert i.	23b. DId	tobacco use co	ntribute (to the cause of death?		
0	hat the								10	Yes 2 No	3 Pro	obably 4 Unknow		
Records,	8 5 2	l by									T 045 14			
0	been s	Completed							24e. Wes	en eutopsy rmed?	9/	Vara autopsy findings vaileble prior to ompletion of ceuse		
ec	¥ 00 0	npl									of	f deeth?		
H	The la ate he page	Son							10	Yes 2 No	1	☐ Yes 2 No		
Vital	efclan: The certificate irector, pag	Be (25. Wes case referred to medical					26. Placa of Dee	th (Check only o	na)				
2	s ca	To	examiner? 1 ☐ Yes 2 No	Hospitel: 1 K	Inpatient 2	ER/Outpatient	3 DOA	ther: 4 Nursing H	ome 5 Resid	dence 6 Oth	er (Speci	ifv)		
0			27. Menner of Deeth	28a. Dete	of Injury	28b. Time of	28c. inj			now injury occur				
sion	14.15	atio	1 ☑Netural 5 ☐ Pendin 2 ☐ Accident investig	,	nth, Day Year)	Injury		ork / ☐ Yes 2 ☐ No						
S	116	fice	3 ☐ Suicide 6 ☐ Could r	ot be 28e. Plec	e of Injury - At ho	me, ferm, stree	t, fectory, office	9	28f. Location (S	Street end Numl	per or Rur	ral Route Number,		
in	d in the	Certification:	4 ☐ Homicide determ	build	ling, etc. (Specify	1)			City or Tov	vn, Stete)				
	Brand.		29a. Cartifier XCertifyin	Physician: To the	a hest of my know	wledge deeth o	courred at the	tima, data and piece,	and due to the	causa(s) and m	anner as o	etatari		
	To the Hos within 24 h To the Fun completely	edical	(Check only 2 Medical I	xaminer: On the b	easis of examinet	ion end/or inves	stigetion, in my	opinion, deeth occur	red et the time,	dete end placa,	end due t	to the cause(s)		
	ithin of the	Z e	29b. Signeture and title of pentilion	2001	//	1.000	29c. Licer	nse number		29d. Dete signe	d (Month	Dev. Year)		
	8 ∓ 8 →		DOUGLAS MEL	AUGHLIN	LT, MC.	USN				18 MAR				
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			30. Neme and eddress of person											
			NATIONAL NAVAL				n, FID							
	Sta	_	31. Dete filed (Month, Day, Year)	"_ 32a	adistrat's Sidna	INTO								
	Registr	ar	WHY I 9 1921	U										

				ficate of Death	Reg.	97 081.8	6								
П	Physic	ian	1. Decedent's Name (First, Middle, Last)		2. Date of Deeth Month	Day Year 3. Time of De-									
	/Medi		Maryland Kedding		March 1	7,1997 0815	,								
	Examir	ner	4e. Fecility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death	4c. County of Death									
			Northwest Hospital Center	Randall:		Baltimore									
	Funeral		1 D M 2 D E	Under 1 Year If Under 24 Hrs onths Days Hours Min.	(Month, Day, Ye	9. Birthplace (State or Fo	reign								
	Director		214-01-6017A 85		Aug 24, 1	911 Maryland									
	land w		10a. State 10b. County 10c. City, Town or Locati	on		10d. Inside City L	imits								
	Mary Fed	ō	Maryland Baltimore Reisters	torm		1 ☐ Yes 25									
	1 the	Director		10f. Zip Code	10a.	Citizen of What Country?									
	3a o		29 W. Chestnut Hill Lane Apt Al	21136		USA									
	ges 1 and 2 should be filed within 72 hours aftar death with the Maryland it of Health and Mental Hygiana. If Itam 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic svent, the Medical Examinat must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	Decedent of Hispenic Origin? (S	pecify Yes or No-	14. Race - American Indian,	-								
0	or he		1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No	s, specify Cuben, Mexican, Puer	o Rican, etc.)	Bleck, White, etc.									
02	sl., o	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	Yes 2⊠ No Specify:		Specify: White									
21215-0020	72 hc	Completed	15. Decedent's Education 16a. Decedent (Specify only highest grade completed) (Give kind	's Usual Occupation	ting 16b	. Kind of Business/Industry									
2	a. an	d	Elementary/Secondary (0-12) College (1-4or 5+)	d of work done during most of wor NOT use retired)	E1	glish-American									
2	filed within Hygiana. Rher than ent, the Me	S	8th Grade Clerica			iloring Company									
ng	d oth	Be	17. Fether's Name (First, Middle, Last)		ne (First, Middle, Maid										
3	should be and Mentai is marked or umatic sve	2	Morgan Bowen		ieve Watso										
Mai	2 sho end is me raum		19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing A	ddress (Street end Number or Ru	ral Route Number, Cit	y or Town, Stete, Zip Code)									
altimore, Maryland	lealth m 27 her t			Chestnut Hill La		terstown, MD 2113	6								
0	or of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cremator	ony or other place)	Date 20c.	Location - City or Town, State									
tim	tment tant:		4 □ Donation 5 □Other (Specify) Lorraine Pa	rk Cemetery	3-19-97 W	oodlawn, Maryland	1								
Bal	permit. Pages 1 end 2 Department of Health e Important: if Itam 27 is any Injury or other tra once.			ame and Address of Fecility	al Directo	ra Ina									
	705 e 0		Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133 23a. Path. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate												
		23a. Path. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.													
	Physician / /Medical		Onset end Death												
	Examiner		disease or condition resulting in death) e. Progressive trypichem (a day) Due to (or as a consequence of) A day (A day)												
		- a		ice of		101									
	nsit insit	Examiner	b. retained Se	retur		14 dan	1								
Ć,	n end	Exa	Sequentially list conditions, if any, leading to immediate cause. Einter Underlying	ce of):			-								
68760,	flicete be executed 3 physician end as the buriel-transit	edical	Ceuse (Disease or injury												
9	75 ED 65		resulting in death) Lest Due to (or as a consequent	De 01).											
Box	death certif e ettanding ed for use a	Physiclan/M	d												
	0 0 0	sicle	Part II. Other significant conditions contributing to death but no resulting in the under	tving cause given in Part I	23b. Did tobac	co use contribute to the cause of de	eath?								
P. 0.	The law requires thet the ste has been signed by the bage 2 should be detache	hy			1 ☐ Yes	2 € No 3 Probably 4 Unk									
	gned og de	by F	Chrane rend gardens												
Vital Records,	v require been sig should t	8			24e. Was an au	24b. Were autopsy findir evailable prior to	ngs								
သွ	aw requisite been 2 should	Completed			periorined	completion of cause of deeth?	91								
œ.	The law	E O			1 ☐ Yes	ADNo 1□ Yes 2□ No	//								
ta		Be C	25. Was case referred to medical	26. Place of Dea	ith (Check only one)										
>	Physici this ce ral direc	To	examiner? 1 ☐ Yes Hospital: ☐ Inpatient 2 ☐ ER/Outpatient 3	Othor		6 Other (Specify)									
0	ding Ph h. After th funeral		27. Menner of Death 28a. Date of Injury (Month, Dey Year) 15 Nature 28b. Time of Injury Injury	28c. Injury at Work?	28d. Describe how in										
0	ath. xr. Af	atic	2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No											
Division of	or Attendation of Attendation of Director:	ertification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number,									
0	Ital o	0													
	Hosp 14 hou Fune tely fi	edicai	29a. Certifier (Check only 2 Medical Examiner: On the bast of my knowledge, death occ (Check only 2 Medical Examiner: On the basts of examination and/or investigation)	curred at the time, date end place getion, in my opinion, death occu	, and due to the ceuse rred at the time, date a	o(s) end menner as steled. and place, and due to the cause(s)									
	To the Hospital or Attending Physician: To the Tuneral Director Atter this certification to the Funeral Director Atter this certification belief filled in by the funeral director,	Med	one) end manner stated. 29b. Signature and hitle of certifier	29c. License number			-								
	L X L O		and the contine	A A A A	290.	Date signed (Month, Day, Year)									
			Howard > publi, ms	048192	2	111147									
1			30. Name and address of person who completed cause of death (Item 23e) (Type, Prin	1)	111111	~ 21117									
			Howm THOSS (m) LO COSSAONS ON 31. Date filed (Month, Day, Year) 32. Registra's Signature	THY OWING	mices, o	~ 2111/									
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	ndill											



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death ^D997 March 15, **Physician** 8:17 mm /Medical Frances ROZANSKI 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Center Rosedale Baltimore 5. Social Security Number 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 4 - 14 - 18 9. Birthpiece (State or Foreign Funeral Months Days 1 M 2 KF 215-03-8101 78 Yrs. Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. inside City Limits must be notified at Director 1 ☐ Yes 2 ☐ No MARYLAND N/A BALTIMORE tha 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 23a or 810 S. GLOVER STREET 21224 USA daath Funeral Heme 2 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Wes Decedent of Hispenic Orlgin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: WHITE à 3 Widowed 4 □ Divorced natural Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiane. marked other than Elementery/Secondary (0-12) College (1-4or 5+) 8 YEARS HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be Pagas 1 and 2 should be nant of Health end Mental JOSZEF CHRONOWSKI MARYANNA CIESLA 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) .00 nt of Health e : If Item 27 is or other tra MR. JOSEPH ROZANSKI 8660 SAXON CIRCLE BALTO, MD. 21236 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burlel 2 ☐ Cremetion 3 ☐ Removel from State permit. Paga Department of Important: If any Injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) STANISLAUS CEM. 3-21 BALTO. MD. ature of Funerei Service Lice 22. Name end Address of Facility
KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVENUE BALTO. 21222 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one ceuse in each line. val Bet **Physician** /Medical immediete Ceuse (Finel diseese or condition resulting in death) **Examiner** Examiner The law requires that the death certificate be axecuted burial-transi Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or as a consequence of) P.O. Box 68760, physician s tha burial Physician/Medical Due to (or as a consequence of): signed by the attending be deteched for use Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 D Onknown Records, þ 24b. Were eutopsy findings available prior to completion of ceuse of death? 24e. Wes en eutopsy performed? Completed paga 2 cartificata 2 No 1 Yes 1 ☐ Yes 21 No Division of Vital 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospitel: 2 No 1 Inpatient Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA this funarel 27. Manner of Death Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred i or Attending P saftar death. Director: Aftar 1 Dieturel 5 Pending investigation 1 Yes 2 No 2 Accident tha 6 Could not be 3 ☐ Sulcide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 - Homicide Hospital within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

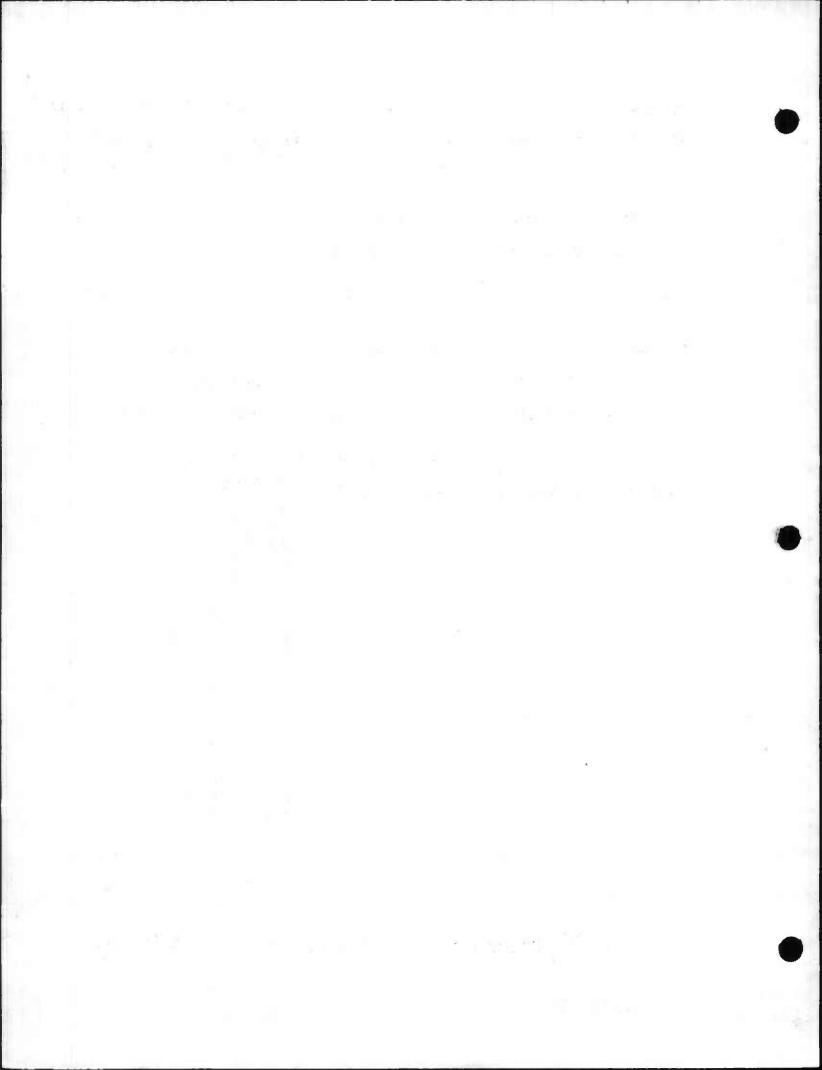
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner steted. Medicai 29a. Certifier (Check only one) 29b. Signeture end title of certific 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Dete filed (Month, Day,

MAR 1 9 1997

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

riogioti ai



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Dete of Daeth **Physician** RICHARDSON DARLENE MARCH :56 PM /Medical 10 4e. Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HOSPITAL HARBOR BALTIMORE 5. Sociel Security Number if Undar 1 Year | if Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Deta of Birth (Month, Day Year) 11/24/55 9. Birthplece (State or Foreign **Funeral** 1□M 200 F 41 Deys Hours 213-62-9866 BALTIMORE, MD Director Usuei Residence of Decedent 10b. County 10c. City, Town or Location 10d. insida City Limits raf, or items 23s or 28s-f show Examiner over be notified at **Funeral Director** 1 Yas 2 No MARYLAND BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 2609 KENT STREET 21230 Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexican, Puarto Ricen, atc.) 12. Was Decedent Evar in U,S 14. Race - Americen Indian, Armed Forces' filed within 72 hours efter 1 Navar Married 2 Married 1 ☐ Yas 2 No If Yes, Give Baltimore, Maryland 21215-0020 natural, or 1 Yas 2 No Specify: AFRO.AMERICAN Be Completed by 3 ☐ Widowed 4 ☐ Divorced Yeer or Datas: 16e. Decedent's Usuel Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) other than Collaga (1-4or 5+) COOK RESTAURANT permit. Pages 1 and 2 should be filed Department of Health end Mental Hyg Important: If Item 27 Is marked other any Injury or other traumatic event, 17. Fether's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Meldan Surname) JAMES RICHARDSON THELMA HENRY 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) CANDACE RICHARDSON 2609 KENT STREET, BALTIMORE, MARYLAND 21230 20b. Plece of Disposition (Neme of cemetery, crametory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Steta 1 Buriel 2 □ Cremetion 3 □ Removel from State 3/18/97 LANSDOWNE, MD. 4 ☐ Donetion 5 ☐ Other (Specify) ZION CEMETERY ESTEP BROTHERS FUNERAL HOME, P.A. 21. Signature-of Funeral Service Licenses 1300 EUTAW PLACE, BALTIMORE,MD. 21217 ease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, is. List only one cause on each line. 23a, Part1. Enter the/difear shock, or heart failure. Approximete intervel Between Onset end Death Physician /Medical Immedieta Cause (Finel diseese or condition rasulting in deeth) DNEUMONIA 1 WEEK Examiner Due to (or as a consequence of): IYEAR. Examiner ate hes been signed by the ettending physician and page 2 should be deteched for use as the buriel-transit Physician: The lew requires that the death certificate be executed Sequentielly list conditions, if eny, leading to Immediata ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Dua to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Dua to (or as a consequance of): Pert ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? MALNUTRITION 1 Yes 2 No 3 Probably 4 nknown by GASTROINTESTINAL BLEEDING Certification: To Be Completed 24b. Were autopsy findings 24a. Was en eutopsy eveilebia prior to completion of ceuse of death? potal or Attending Physician: The lew ours after death. eral Director: After this certificate hes filled in by the funeral director, page 2: 1 ☐ Yas 2 ☑ No 2 No 1 Yes 25. Wes cese referred to medicei 28. Place of Deeth (Check only ona) Hospitel: 1 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□No 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Dascribe how injury occurred 28c. injury at Work? 5 Panding investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28a. Piece of Injury - At home, farm, straet, factory, office building, etc. (Spacify) 4 Homicide To the Hospital o within 24 hours af To the Funeral DI completely filled is Medical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, and due to the ceusa(s) end manner es steted. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, daeth occurred at the time, date and piece, and due to the cause(s) end manner stated. 29b. Signature end title of certifier 29d. Dete signad (Month, Dey, Year) Thomas - INFERN MEDICING AS 2441614-38 30. Nema and eddress of person who completed cause of deeth (Item 23a) (Type, Print) HOSPITAL CENTER, BALTIMORE, MD HARBOR THOMAS 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State MAR 1 9 1997 Registrar

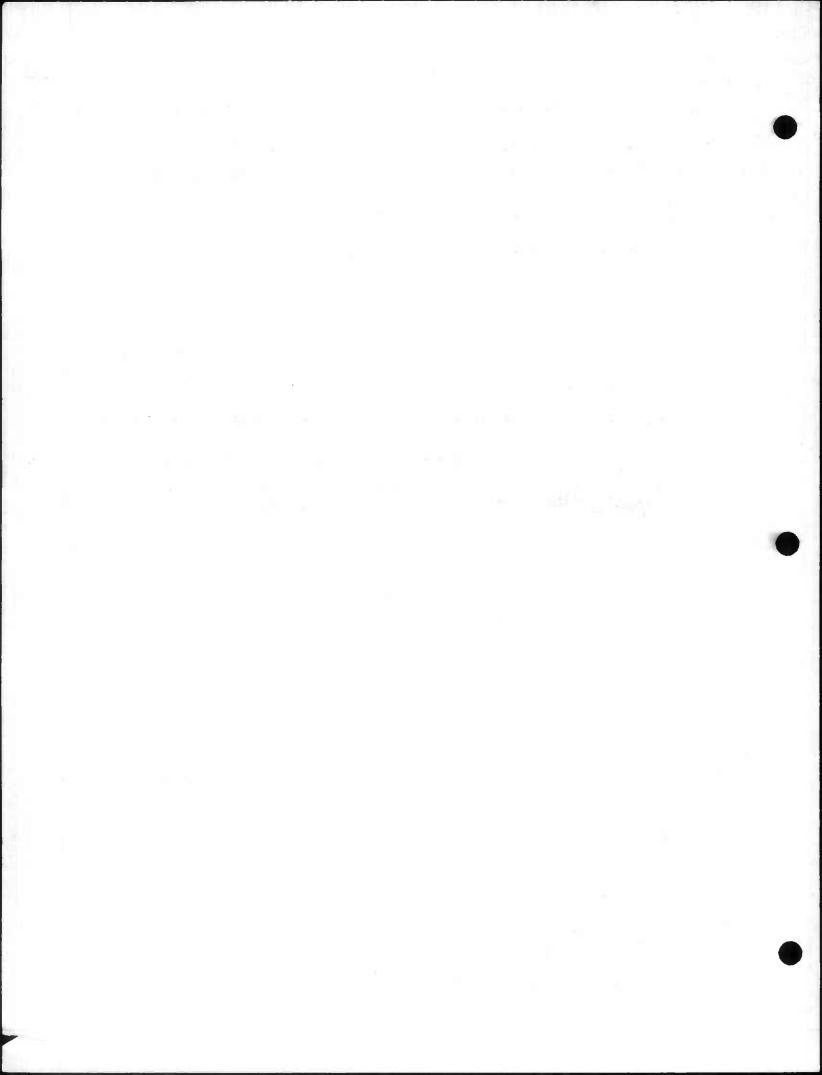
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			State	of Maryland /	Certificate of	lealth and Mental H Death	ygiene 97	08489
	Physici /Medi		1. Decedent's Neme (First, Middle, Last) Thomas &.	RIDDY	toe	2. Dete of D Month		3. Time of Death 7 0958
	Examin Funeral Director		4e. Facility Neme (If not institution, give street end of North Arable) 5. Social Security Number 6. Sex 219 80 8324 1 M 2 F Usuel Residence of Decedent	7. Age (In yrs. layt)	birthday) If Under 1 Yeer Morths Deys	Ab. City, Town, or Location of Dec	irith (2) 9. Birthola (2) (2) (2) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4	ace (State or Foreign n) 11and
	ylend		10e. Stete 10b. County	10c. City, To	own or Location		10	d. Inside City Limits
	Ba-f el	Director	Maryland Anne Arundel	Balt	imore			1 ☐ Yes 2 ☒ No
	ath with the 23a or 2 west be re-	rai Dire	7910 Main Street		10f. Zip Code 2122		10g. Citizen of Whet Count	
020	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	Armed 1 X Never Merried 2 Married 1 ☐ Ye If Yes,	ecedent Ever in U,S. Forces? is 2 1 No Give r Detes:	13. Wes Decedent of H If Yes, specify Cubs 1 ☐ Yes 2 2 No	lispenic Origin? (Specify Yes or N an, Mexican, Puerto Rican, etc.) Specify:	1417-4-1	
21215-0020	should be filed within 72 hours nd Mental Hygiene. marked other than "natural", matic event, the Medical Ext	Completed	The state of the s	nd) 18 9 (1-4or 5+)	Be. Decedent's Usuel Occup (Give kind of work done life. DO NOT use retired Bar Tender	ation during most of working 1)	16b. Kind of Business/Inde	ustry
	Hygid Ther	e Co	10th 17. Fether's Neme (First, Middle, Last)		Dar Tender	18. Mother's Neme (First, Middl		
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Man	2 should land Men le marked summited		19e. Informent's Neme/Reletionship (Type, Print)			and Number or Rural Route Num		
	1 and Health em 27 ther tr		Lawrence Rippetoe Jr. 20e. Method of Disposition		7914 Main Str		ore, Maryland 20c. Location - City or Tov	
Baltlmore,	8= = 8		1 ☑ Bunai 2 ☐ Cremetion 3 ☐ Removel fro 4 ☐ Donation 5 ☐ Other (Specify)	III State	of Disposition (Name of tery, crematory or other please Cross Cem.	3/20/97		
Bal	pemil. Pa Departmer Important: any injury once.		21. Signeture of Funerel Service Ucensee	ree	22. Neme end Addre	ss of Fecility Gonce ie Highway Bal	Funeral Home timore, Md. 2	
	Physician /Medical Examiner	er	23a. Pert1. Enter the disease, or complications the shock, or heef feliure. Ust only one cause or Immediate Cause (Finel disease or condition resulting in deeth)	Seizu	_	g, such es cardiec or respiretory	errest,	Approximete Interval Between Onset end Death
Box 68760,	death certificate be executed e attending physician and yd for use as the bunal-transit	VMedical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last	,	a consequence of):			
B.	death e atter	iciar	Pert II. Other significent conditions contributing to	death but not resulting	in the underlying cause giv	en in Pert I 23b Die	d tobacco use contribute to	the cause of death?
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a	E 88		or w					Yes 2□ No
on of Vital	ing Phys h. After this funeral di	tion: To Be	27. Manner of Deeth 28a. Det		Outpetient 3 DOA Oth Time of Injury M 10	4 Nursing Home 5 Hes		1
Division	al or Attending s after death. Il Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. Ple	ce of Injury - At home, ilding, etc. (Specify)	ferm, street, lectory, office	28f. Location	(Street and Number or Rural own, State)	Route Number,
manual	To the Mospital within 24 hours a To the Funeral Completely filled	edicai	(Check only 2 Medical Examiner: On the	he best of my knowledge basis of examination eanner stated.	end/or investigetion, in my o	ne, dete and piece, and due to the pinion, deeth occurred at the time	, dete and plece, end due to	the cause(s)
	To the To the Company	M	29b. Signeture end title of certifier William R.	Depur	fy 29c. Licens	onumber 06054 5 America	29d. Dete signed (Month, D	ay, Year)
_	\		30/Neme end eddress of person who completed ca		(Type, Print)	5 Ameri	ica 211	235
	Sta Registr	-	31. Dete filed (Month, Day, Year) 32. MAR 1 9 1997	Registrer's Signeture	indella			

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				State of N	larylar		irtment of tificate o		d Mental H	ygiene Reg. No.	97 0	18490
	Physic /Medi		1. Decedent's Name (First, Middle, La		'				2. Date of D Month	Day	Year	Time of Deeth
7	Examir		4e. Facility Name (If not institution, giv	pital				Balti		N,	of Death	
	Funeral Director		5. Social Security Number 6. S 217-34-9724 Usual Residence of Decedent	ex 7. A □ M 2X0 F	90	last birthday) Yrs.	If Under 1 Ye Months Da		Min. (Month, L	Sirth Day, Yeer) 24,190	9. Birthplece Country) 5 Mary	(State or Foreign
21215-00; d within 72 hours giene. rr than "natural", fre Med cel Ex	cto	10a. State 10b. County			y, Town or Lo altimo						Inside City Limits	
	ral Dire	N/A 10e. Street and Number 1932 Christian 11. Meritei Status 1 Never Married 2 Married	Street			10f. Zip Cod 2122			10g. Citizen of United			
	by Fune	11. Meritei Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☐ if Yes, Give Year or Dates	? X No		Vas Decedent Yes, specify C		? (Specify Yes or fuerto Rican, etc.)	No- 14. Rac Bla Specifi	ce - Americen I ck, White, etc.		
	Completed by	15. Decedent's Ed (Specify only highest gra Elementary/Secondery (0-12)		5+)	16e. Deced (Give life. L homen		cupation ne during most of tired)	working	own he		ry	
Maryland	aryland 212: should be filed within a Mental Hygiene. marksd other than imatic event, the M	To Be (17. Father's Name (First, Middle, Last) Louis Walther					Eliza	Name (First, Middle beth Lo	owery		
	1 and 2 sho Health and Pm 27 is m		19a. informent's Name/Relationship (Betty M. Roper			19b. Mailing Address (Street end Number or 1932 Christian St. Place of Disposition (Name of			reet Ba	altimore	e, MD	21223
timor	Pa Pa		20a. Method of Disposition 1 Bunial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specified)	Removal from State Loudon Park Cemete Cemetery, crematory or other place)					3/18	Baltime		State Maryland
Bal	permit. Pa Departmen Important: eny Injury		21. Sometime of Foodul Service Licen	au		An 13	nbrose 328 Su	Funera 1phur S	Road 21227			
	Physician /Medical Examiner	94	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Finel disease or condition resulting in death)	a.	line.	PS15		aying, such es car	diac or respiretory	errest,	Inte	proximate erval Between eval Between eset and Death clays
68760,	ss that the death certificate be executed gned by the attending physician end be deteched for use as the bunel-transit	edical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	bC		r as a consequ					1	daye.
Box	death certifica attending ph d for use es t	Physician/M	Pert II. Other algnificant conditions or	d.	hut ant rea	utainer in abour	de de de se se se se se	share is Oracl	eah Di	4.4.4		
s, P.O	ss that the death gned by the atte be deteched for		Total. Other algument conditions of	minibuting to death	Dut not 195	oning in the ur	denying cause	gwen in Pan I.		d tobacco usa co ⊒ Yes 2 □ No		y 4 Unknown
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Vital F	Physician The this certificant all director	Be	25. Was case referred to medical exeminer?	Maniado					Deeth (Check only	Yes 2 No	1 □ Ye	es 200 No
Division of	Attending at deeth.	Certification: To	1 Yes 2 No 27. Manner of Deeth 1 Naturel 5 Pending 1 Nestigation 3 Suicide 6 Could not be 4 Homicide	28e. Place of Ir	ury a <i>y Year)</i>	28b. Time of injury	28c. lr	njury at Vork? ☐ Yes 2 ☐ No	ursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			oute Number,
٥	To the Rospital or within 24 hours after To the Funeral Dir completely filled in	edical Cer	29a. Certifier (Check only one) (Check only one)	valcian: To the best	of my kno	wledge, deeth	occurred at the	time, date and pl y opinion, death o	ace, and due to th	e cause(s) and ma	anner as stated	d. cause(s)
	To the To the comple	Mec	29b. Signature and title of certifier	Pro	idied.			ense number		29d. Date signe March		(Year) 1997
	13			Sam.L	MD		Agnes	1706071 1708 pil	tal			
	Sta	-	31. Dete filed (Month, Dev. Year) MAR 1 9 1997	32. Regis	rar's Signa	ture Randoll	2					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Data of Death Month **Physician** mary Rhuhottom 97 /Medical 4a. Fecility Nama (If not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE RMDA / STOUN

if Under 24 Hrs. 8, Date of Homblel 5. Sociel Sacurity Number 7. Aga (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Country)

ARVIAND **Funeral** 1□M 20F 578- HY-0635 Director Usuat Rasidance of Dacedant 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 TYas 2□ No md Director BAHIMUR 10e. Straat and Numbe 10f. Zip Coda 10g. Citizan of What Country? ŏ 400 21223 Items 23a millington Aur Funeral death 14. Raca - American Indien, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No 11. Marital Stetus Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) filed within 72 hours after 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No "natural", or BLAC þ 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highest grada complated) 16a. Decedant's Usual Occupetion (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within Department of Health end Mental Hygiene. Important: If item 27 la marked other than " Elemantary/Secondary (0-12) Collaga (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Surname) GRI 19e. Informent's Name/Relationship (Type, 1/8 20a. Mathed of Disposition 1 Burial 2 Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signeture Funeral Sarvice Licente diseasa, or complications that causad the death. Do not enter the mode failure. List only one cause on each line. Approximete Interval Between Onsat and Deeth Physician Conclude Ouy famin Dua to (or as a consequence of): /Medical Immediata Ceuse (Finel minues disease or condition resulting in death) **Examiner** Examiner -transit Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Ceuse (Diseasa or Injury thet initieted events rasulting in daath) Last and and comyopan Imital Reguss ettending physician a for use as the burial-P.O. Box 68760. Physician/Medical the d be detached Part II. Other eignificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Wnknown Awemis Records, þ 24b. Wara autopsy findings avaitable prior to completion of cause of death? ete has been si page 2 should Be Completed 7.SBF 24a. Wes en autopsy certificete 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 Z No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartification properties of the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director; to the funeral director director directors di 25. Was casa referred to medical 26. Plece of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 27. Mennar of Deeth 28c. Injury at Work? 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 5 ☐ Panding invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be detarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Placa of Injury - At home, ferm, streat, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a, Certifian

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Registrar

31. Dete filed (Month, Day, Year) MAR 1 9 1997

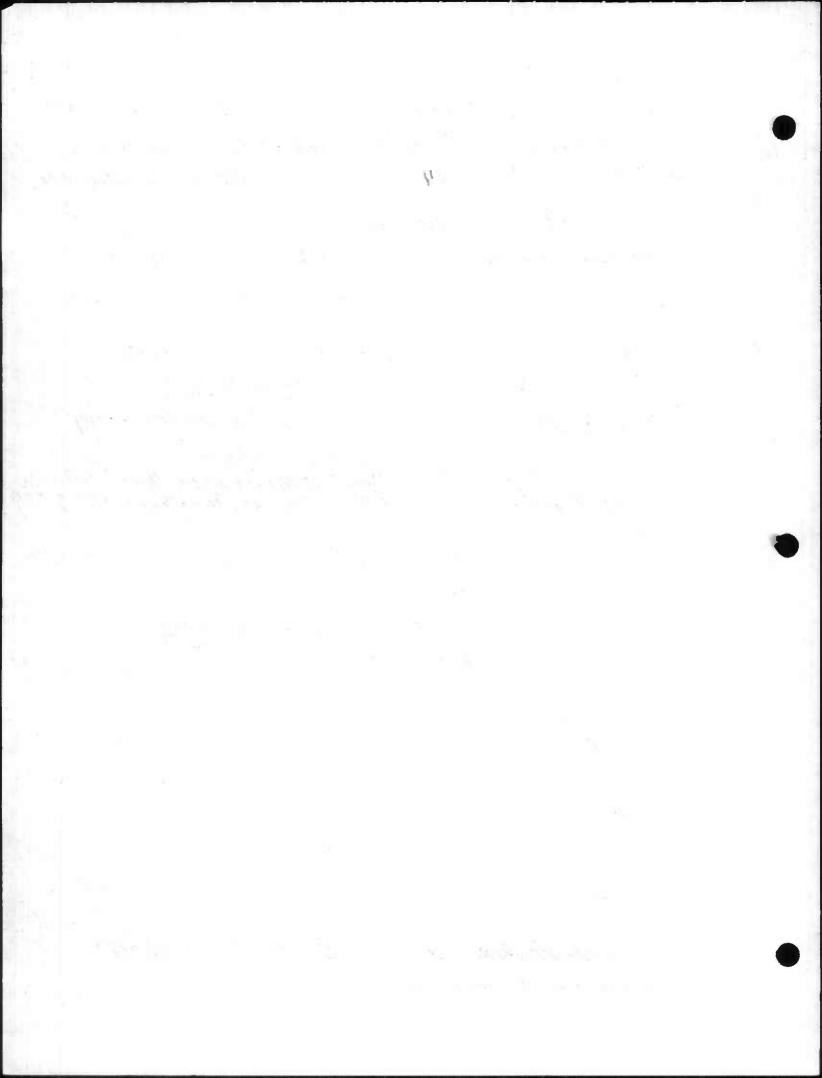
30. Nama and addrass of parson who complated causa of death (Itam 23a) (Type, Print)

29b. Signature and titla of certifian

STHNFUL H. MALINOW 32 Registrar's Signature guia Davidson-Randelle 29c. License number

3675 Old com Re

29d. Data signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		Item 1 Per PHY Film 1. Decedant's Nama (First, Middla, L	G745 3-18-9		-	ificate of	dealth and Name of the second	2. Data of De	Reg. No.	97	0.84.9 3. Time of Death		
Physiciar /Medica		Har	ry	Alvin		RICE	Jr.	March	10, Day 199	7 ^{Yaar}	5:10 P		
Examine Funeral Director	er	236-26-3080	ive	er) Aga (In yrs. last i 70	birthday) Yrs.	If Undar 1 Yaar Months Days	Freder If Undar 24 Hrs. Hours Min.		Fr	ederi	ck laca (Stata or Fore VIRGINIA		
the Marylend 28a-f show	tor	Usual Rasidance of Dacedant 10a. Stata 10b. County MARYLAND FREDERI	CK	10c. City, To	wn or Loca REDER					10	0d. Insida City Lim		
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d within 72 hours piene. r than "natural", the Medical Ex	Be Completed	15. Decedant's E (Spacify only highast gr Elamantary/Sacondary (0-12) 12	ducation ada complated) Collega (1-40	r 5+)	(Giva ki lifa. DC		during most of work d)	sing	16b. Kind of B				
	10 Be C	12 2 CAMERA REPAIR 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Last)					18. Mothar's Nam CLARA	a (First, Middle BELLE					
nd 2 shoulth end N 27 is mer r traumel		19a. Informant's Nama/Ralationship (Type, Print) MARTHA P. RICE, WIFE 19b. Malling Address (Streat and Number or Rural F									1		
Ses		20a. Mathod of Disposition 1 ☐ Buriai 2 ☑ Cramation 3 [4 ☐ Donation 5 ☐ Othar (Speci		a cama	tary, crema	ion (Nama of tory or other place AN CREM		Data 12/97	20c. Location -				
permit. Pag Department Important: It any injury o		21. Signatura of Funaral Sarvica Lice	-Barke	V			BARBER F			2088	2		
Physician //Medical Examiner street beacarded as the burlander of the burl	Ical Examiner	Immediata Causa (Final disaasa or condition rasulting in daath) Saquantially list conditions, if any, laading to Immediate ceusa. Entar Underlying Causa (Disaasa or Injury that Initiated events		Dua to (or as a Dua to (or a) Dua to (a conseque	1-	13110				4 6 4 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6		
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To the Hospital or Attendi within 24 hours efter deeth. To the Funerel Director: A completely filled in by the fi Medical Certificati		29a. Cartifiar 1 Certifying Ph	ysicien: To the bas niner: On the basis and mannar s	t of my knowledg	ja, daath o nd/or Invas	ccurred at tha tin	na, data and place, pinion, daath occurr	and dua to the	causa(s) and ma	annar as sta and dua to	ated. tha ceusa(s)		
To the within To the comple		29b. Signatura and titla of certifiar 30. Nama and addrass of person who	2	la) (Type, Pr	29c. Licanson D 12			29d. Data signed				
State Registrar		Dr. P. Gregory 31. Data filed (Month, Day, Year) MAR 1 9 1997	Rausch, M		West	Seventh	Street,	Frederi	ck, Mar	yland	21701		

DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) **Physician** /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth **Examiner** Levindale Hebrew Home Baltimore N/A 7. Age (In yrs. last birthdey) If Under 1 Yeer If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) June 7, 1896 Birthpiece (State or Foreign Country) **Funeral** Deys 1□M 25F Director Yrs. 215-76-5346 100 Poland Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Nem 27 is marked other than "natural", or Nema 23s or 28s-f show other traumatic event, the Modical Examiner must be nothled at 1 X Yes 2 No Directo MD N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6001 Park Heights Ave 21215 U.S.A. Funeral Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. permit. Peges 1 and 2 should be filed within 72 hours effer a Department of Health and Mental Hygiene. Introcrant: If them 27 is merked other than "natural", or then any Injury or other traumatic event. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☒ No if Yes, Give Yeer or Detes: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No þ Specify: 3 ☑ Widowed 4 □ Divorced White Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Seamstress Clothing 17. Fether's Neme (First, Middle, Last) Be Isaac Kruk Unknown 19e. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr Henry Bernstein (Nephew) 562 Kennington Road, Reisterstown, MD 21136 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - Cify or Town, Stete Buriei 2 Cremetion 3 Removel from State
4 Donetion 5 Other (Specify) 3/16/97 Moses Montefiore Baltimore, MD 22. Neme end Address of Fecility
Sol Levinson & Bros. 8900 Reisterstown Rd, Pikesville, MD 21208 23e. Pert1. Enter the disease, or complication of at caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one crution on each line. Approximate interval Between Onset and Deeth Physician /Medical Immediete Cause (Finel diseese or condition resulting in deeth) Examiner Examiner physician and the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Box 68760. SUPSIS Physician/Medical Due to (or es e consequence of): Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yaa 2 ☐ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2₽No 1 ☐ Yes 2 ☐ No degenes Division of Vital 25. Wes case referred to medical Be 28. Piece of Deeth (Check only one) exeminer To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral directorial. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 Ne 4 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of injury (Month, Day Year) 27. Manner of Death 28c. injury et Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 Naturel 1 Yes 2 No Investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 HomicIde 1. Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and placa, end due to the cause(s) end manner as stated.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) Morch 30. Name end eddress of person who completed cause of deeth (item 23a) (Type, Print) W. Belveder CONSUEZA 31. Dete flied (Month, Day, Year) 32. Registrer's Signeture 21215-

State Registrar

97-1216-510

Item 23,27,28abcdef Per MEO Film G746

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

of Mar	yland /	Department of Health and Ment	al Hygiene	07	00101
4-8-97	rja	Certificate of Death	Dea No	91	08494

Physician /Medical Examiner
Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as once.

Baltimore, Maryland 21215-0020

Physician /Medical Examine

ivision of Vital Records, P.O. Box 68760,

Decedent's Na	me (First, Middle, Las	st)					2. Date of De Month	ath Day	Year	3. Time of Death		
BENNIE		R.			SIM	PKINS	MARCH		997	5:45P.M.		
4a. Facility Name	(If not institution, give	street end number)				4b. City, Town, or	Location of Deetl					
SINAI H	OSPITAL					BALTIMO	ORE		N	11		
5. Sociel Security		9x 7. Ag □ M 2⊠F	e (In yrs last bir	rthday) If	Under 1 Yea onths Days			th (v. Year)	9. Birth	nplece (State or Foreign		
434-82-	0060	L M 223F	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Yrs.			(Month, Da 9/30/	06	LA			
Usuel Residence	of Decedent 10b. County		10c. City, Town	m or Locatio	2607	01				404 1-14-00-11-1		
MD					MD 21	Glen Ave	enue-			10d. Inside City Limits 1 ☑ Yes 2 ☐ No		
		.)	Daiti									
10e. Street end N		-		10	of. Zip Code			10g. Citizen of	What Co	untry?		
	len Avenue				2120			-yes U				
11. Maritel Status		12. Was Decedent Armed Forces?	Ever in U.S. UNKNOWN	13. Was	Decedent of s, specify Cul	Hispanic Origin? (S ben, Mexican, Puer	specify Yes or No to Rican, etc.)		ca - Ame	ncan Indian, e, etc.		
	rled 2 Married 4 Divorced	1 ☐ Yes 2 ☐ I If Yes, Give Year or Dates:	No	101	1 Yes 2 No Specify: Specify: Specify: Black							
(Soe	15. Decedent's Ed	ucation de completed)	16a.	Decedent's	Usual Occu	pation	rkina	16b. Kind of E	Business/I	ndustry		
Elementary/Sec		College (1-4or 5	i+)	life. DO N	OT use retir	during most of wo	in ing					
12		5+		Social	l Work	-		Socia	-	cvice		
	(First, Middle, Last)					18. Mother's Na	me (First, Middle,	, Maiden Sume	me)			
Benjam	in Stephen	lS				Laura	Ruth Rol	berts				
	lame/Relationship (T		1			et and Number or R						
·	E. Donegh	ıy				venue, Ba						
	sposition Cremation 3 1 Double (Specify		20b. Plece of cemeter		n (Neme of y or other pla	ace)	Dete	20c. Location	- City or 7	Fown, State		
21. Signature of F	une al Service Licens	see /	-1122	22. Nar	ne and Addr	ess of Facility						
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FOR DAIL SHA	the disease, or comp	au	laborate Don	Bal	timor	e, Maryla	ind 2120	1		Approximete		
disease or conditi resulting In deeth)	ОП	-	RATE INTO						1			
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that initiated even	5	c	Due to (or as a c	consequenc	a of):							
resulting In death) Last d.												
5							1					
Part II. Other sign	obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown											
							040 141	an autom	245 1	Vere eutopsy findings		
								en autopsy rmed?	e	veileble prior to completion of cause of death?		
								, all		: /		
25. Was case refe	read to modical							Yes 2□No	1	□Yas 2□ No		
exeminer?	(-1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	Hospital:			0.00	hor:	ath (Check only o					
1 X Yes 2 ☐ 27. Menner of Dea	1140	1 LA Inpatie	20b T	itpatient 3	L DOA	4 Li Nursing F	fome 5 ☐ Resident	denca 6 ⊟Oti how injury occu		ny)		
1 ☐Naturei 2 ☐ Accident	5 ☐ Pending investigation	EOUND, De	Year) Ir	njury	28c. Inju	ork?]Yes 2,□No			177			
3 ☐ Suicide 4 ☐ Homlcide	6 La Could not be determined	28e. Pleca of Injubuilding, etc		110			28f. Location (S City of Tab 3607 GLE	Street and Num		ral Route Number,		
29a. Certifier (Check only	1☐ Certifying Phy	sician: To the best of	of my knowledge,	, death occu	urred at the t	ime, dete and place	and due to the	ceuse(s) end m	anner as	stated		
one)	70100	and manner sta	ited.	mixestig								
29b. Signeture and	title of certifier	has the	0			se number		29d. Dete signo	1			
30 Name and add	race of pareon who	ompleted cause of d	noth (Hom 22s) ((Tupo Brica)		· FI · Li ·		ПАКСП	J, 1	771		
(Check only one) 29b. Signeture and	21X Medicat Exami	sician: To the best of iner: On the basis of and manner sta	DENCE of my knowledge, examination and ted.	e, death occi d/or Investig	29c. Licen	ime, dete and place opinion, death occu	a, and due to the irred at the time,	ceuse(s) end m date and place, 29d. Dete signe	anner as and due ed (Month	to the cause(s) , Day, Year)		

State Registrar

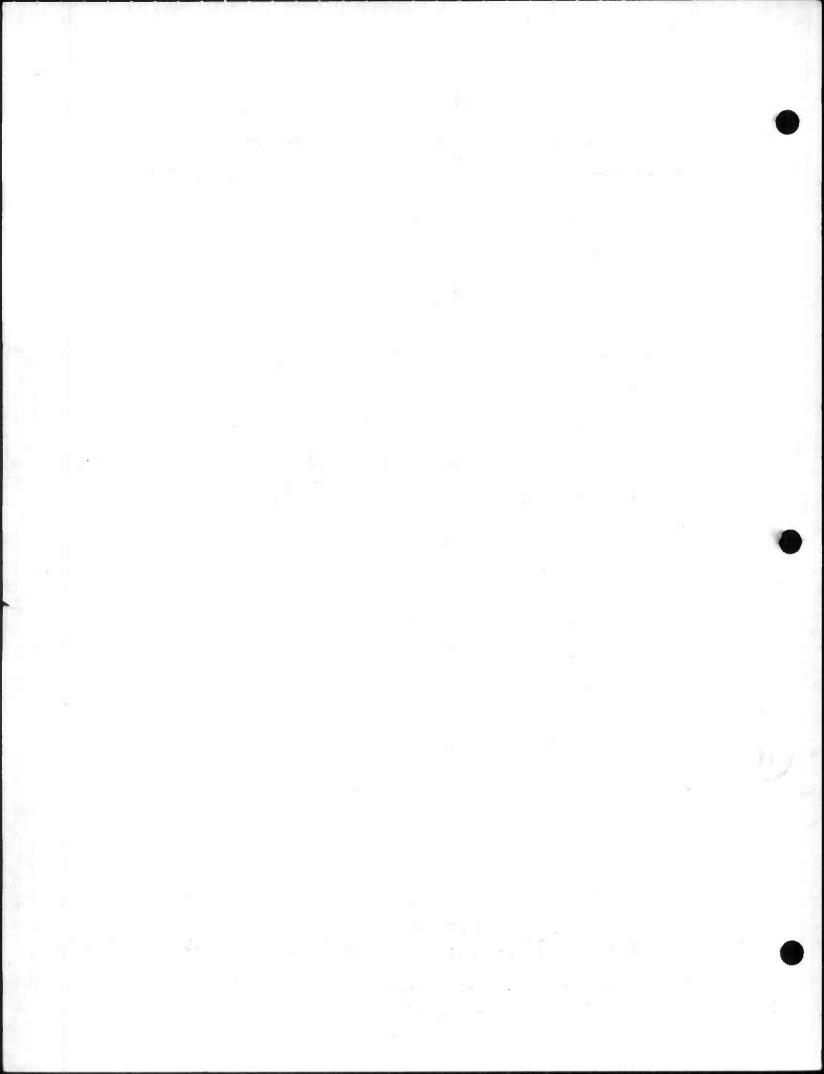
31. Dete filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 08495 Item: 5, per F.H.G-745 3/25/97 reb Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Date of Death **Physician** Month WILLIAM SETTLE 12:45p 1997 March /Medical 16 4a. Fecility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Deeth Examiner Stella Maris at Mercy Hospice Baltimore N/A 5. Social Security Number 210-12-2859 If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□ F Days Hours Yrs. Director 70 22, 1927 Pennsylvania Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow "natural", or items 23s or 28s-f sh bolical Examiner must be notified Director 1 Ves 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5020 East Hoffman Street 21205 U.S.A. Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?

1 ☑XYes 2 □ No 1947—
If Yes, Give
Year or Dates: 1948 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorcad White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumatic event, Ite Medig. 2008. Elementary/Secondary (0-12) College (1-4or 5+) Welder 12th grade Welding Company Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be William Settle Martha Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Eline (Daughter) 5018 Erdman Avenue, Baltimore, Maryland 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Gardens of Faith Cemetery 3-18 Baltimore, Maryland 22. Name end Address of Facility
Schimunek Funeral Home 21. Signature of Funeral Service Licanii 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Metastatic Small Cell Carcinoma of Lung /Medical Immediate Cause (Finel 15 months diseese or condition resulting in death) Examiner Due to (or as a consequence of): Examiner that the death certificate be executed bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? Suprarentricular tachycordia 1 2 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an eutopsy performed? 1 Tyes 2 DONG 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Wes case referred to medical 26. Piace of Death (Check only one) STELLA MARIS AT MERC Other: 4 Nursing Home 5 Residence 6 TOther (Specify) HOSPICE 2 1 Yes 2 INO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Naturai 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 \ Homicide 1 Certifying Physictan: To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) and manner stated. Medical 29a, Certifier Attending 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 17, 1897 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 301 #407 T BALTO, MD. 21202 FELDMAN, MD ST. PAUL MARVIN -32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 1 9 1997 State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Sircar Ronald Shoats 03 08 97 6:28pm /Medical 4a. Facility Name (If not Institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1800 BLK. N. Chester Street NA Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number if Under 1 Year 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months 1**X** M 2 □ F Days Yrs 220-72-9567 **Director** 20 02-23-77 Md. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Md. Na Baltimore Director XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1846 N. Chester Street 21213 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: à Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Grade Laborer Various trades 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fred Shoats Carrie Toller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrie Harris 238 Beale Court Baltimore, Md. 21231 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposit 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from 4 Donation 5 Dother (Specify) Baltimore Cemetery 3-15 | Baltimore, MD 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signature Furtiral Service L WM. C. March FH 1101 E. North Avenue Enter the disease, or confolications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, it, or heart feilure. List only one cause on each line. Approximate Onset and Death **Physician** tmme ate Ceuse (Final disea e or condition resulting in death) /Medical Gunshot wound of the nect **Examiner** Due to (or es a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 X Yes 2 □ No 1 Yes 2 □ No Be 25. Wes case referred to medical 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Hother (Specify) Street Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 No 2 Accident 3-8-97 1815 Subject was Shot 281. Location (Street and Number or Aural Acute Number, City or Town, State) 1860 block Chester street 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Sidewalt Baltimore City, Maryland

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

March 9, 1997

sician and burial-transit that the death certificate be executed P.O. Box 68760, attending physician for use as the buna signed by the a Records, Division

the Maryland

filed within 72 hours after Hygiene.

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If flem 27 is marked other than any injury or other traumetin.

Baltimore, Maryland 21215-0020

r than "naturel", or items 23s or 28s-f show the Mexical Examiner must be notified at

al or Attendin after death. I Director: Aft To the Hospital o within 24 hours at To the Funeral Di completely filled is

> State Registrar

Medical

29a. Certifier

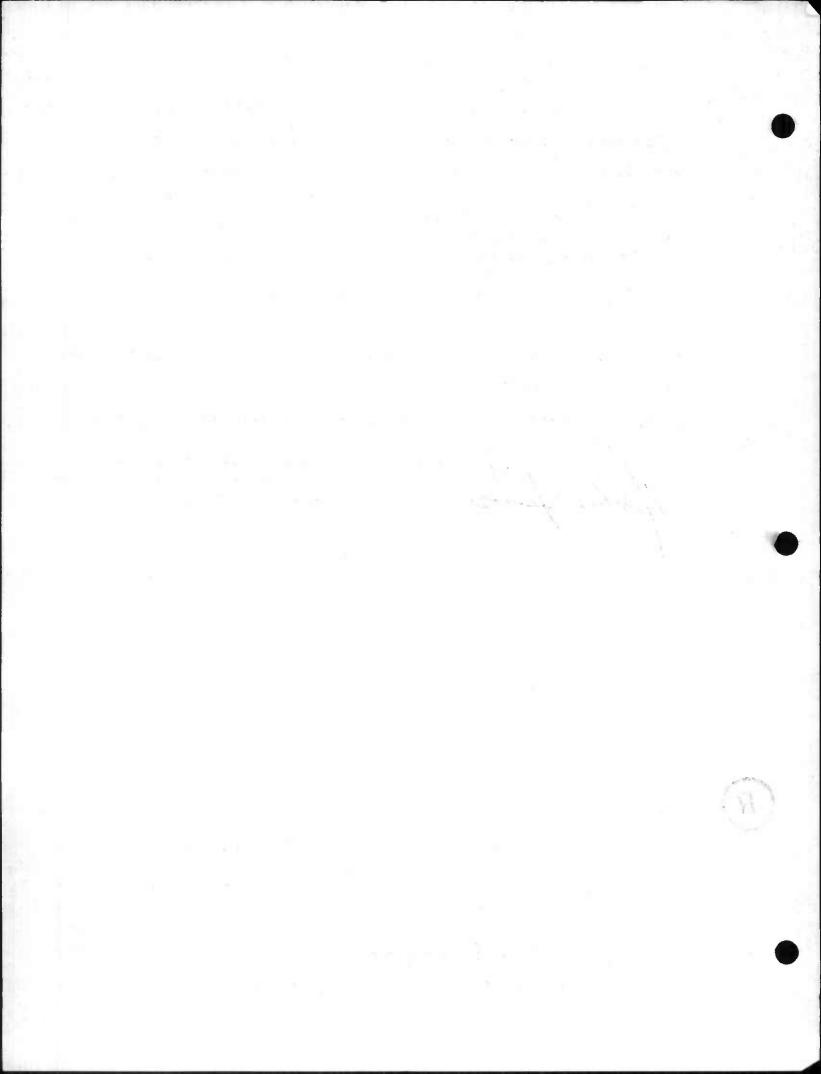
(Check only one)

29b. Signature and title of certifier

Stephen S.
31. Date filed (Month, Day, Year) MAR 1 9 1997

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 08497 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** VERA RITA Month SMITH SZYMASZEK March 8.05 pm /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Baltimorce Baltimore Hospital Harbor 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M 20 F 215 10 2018 Director 90 Yrs. Maryland Usual Residence of Decedent Maryland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Maryland N/A 1 Yes 2 □ No Director Baltimore with the 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 309 Washburn Avenue items 23a 21225 U.S. death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②XNo If Yes, Give Yaar or Dates: 11. Marital Status Was Dacedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education 16e. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grede completed) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiena. Important: If Item 27 is marked other than any Injury or other traumatic event. The Man Elamantary/Secondary (0-12) College (1-4or 5+) 8th Seamstress Clothing 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumama) Joseph Szymaszek Sophia Dobus 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Joan Wojciechowski / niece 205 Falcon Drive Pasadena, Maryland 21122 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removel from Stete 3/20/97 Glen Burnie, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Glen Haven Mem. Park 21. Signelure of Funeral Sarvica Licensee 22. Name and Address of Fecility Gonce Funeral Home P.A. remutelle 4001 Ritchie Highway Baltimore, Md. 21225 23a. Pert1. Enter the disease, or commendations thet caused the death. Do not enter the mode of dylng, such es cardiac or raspiratory errest, shock, or heart feilure. List only the ceuse on each tine. tntervel Between Onsat and Deeth **Physician** /Medical tmmediate Ceuse (Finel Pulmonary hour disease or condition resulting in deeth) Examiner Examiner requires that the death certificets be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting In deeth) Lest pue Due to (or es a consequenca of): physician e Box 68760, Physician/Medicai the Due to (or es e consequenca of) for usa es P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 6 Fibrillation 1 ☐ Yes 2 ☐ No 3 Probably 4 Onknown Records, P 24b. Were eutopsy findings evailable prior to Completed 24e. Wes en eutopsy completion of cause of deeth? page 2 cartificete has 1 ☐ Yes 2 ☐ No 1 ☐ Yas 2 No Division of Vital Be 25. Was case referred to medical 26. Place of Deeth (Check only one) exeminar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 1 Inpetiant Certification: To 2 ER/Outpetient 3 DOA s ofter death.
I Director: After this of in by the funeral d this 27. Mannar of Deeth 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation 1 Neturet 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours of To the Fundral DI completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of cartifier Resident Physician As 244161441 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) HARBOR HOSPITAL CENTER, BALTIMORE ZAFAR Ca Registrate Signedule Call

DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene 08498 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** MARY STRAILMAN 0907 AM MARCH /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth **Examiner** 4c. County of Deeth HARBOR HOSPITAL CENTER BALTIMORE CITY BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** 1□M 2MF 212 09 2376 80 Yrs. Director Jan. 25, 1917 Maryland Usual Residence of Decedent worle 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23s or 28s-f election by a continuation of the Anne Arundel Director Maryland 1 ☐ Yes 2X No Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 113 W. Meadow Road 21225 U.S. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Stetus 14. Rece - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Yes 2 No Specify: Be Completed by 3 Widowed 4 □ Divorced Specify: White The Medical 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker 12th Own Home 17. Father's Neme (First, Middle, Last) parmit. Pages 1 and 2 should be filt Department of Health end Mental Hy Important: If them 27 Is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Meiden Sumeme) Frank Krygier Mary Dubiel 19a. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Dolores R. Toth 982 Waterview Drive Crownsville, Maryland 21032 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1 Burlal 2 ☐ Cremation 3 ☐ Removel from Stete 3/18/97 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 aves 23a. Part1. Enter the disease, or complications that caused the death. Do lot enter the mode of dying, such as cerdiac or respiretory errest, abock, or heart fellure. List only one cause on each line. Physician PULMONARY EMBOLISM Immediete Cause (Finel DAY diseese or condition resulting in death) **Examiner** SEPSIS 3 WEEKS Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events CEREBRO - VASCULAR ACCIDENT DAYS Physician/Medical thet initieted events resulting in deeth) Lest Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? CORDNARY ARTERY DISEASE 1 Yes 2 No 3 Probably 4 Unknown þ HYPERTENSION Completed 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Wes en autopsy performed? DEPENDENT MELLITUS. DIABETES MON-INSULIN 1 Yes 2 ₽No 1 Yes 212 No 25. Wes case referred to medical examiner? Be 28. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) ဥ 1 Yes 2 No 27. Menner of Deeth Certification: 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending Investigation To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Afr completely filled in by the fur 1 ∏ Yes 2 □ No 2 Accident 6 Could not be determined 3 Sulcide 28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 1 Certifying Phyalctan: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) end manner as atated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, dete end placa, and due to the cause(s) end menner steted. edical 29e. Certifier (Check only one) 29b. Signature end title of certifier 29c. License number PGY_11 RESIDENT * AS 2441614 - 42 29d. Date algned (Month, Dey, Year)

MARCH

State Registrar 31. Dete filed (Month, Dey, Year)
MAR 1 9 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HAN WIN TUN , HARBOR HD HARBOR HOSPITAL CENTER. 133. Registrar's Signatura

the Meryland

filed within 72 hours efter

al Hygiene.

21215-0020

Baltimore, Maryland

The law requires that the death certificate be executed

or Attending Physician:

this

After t

death.

Division of Vital Records, P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Deta of Death Month Day **Physician** SCOTT Year IMOGENE MARCH 18,1997 5:27 a /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. lest birthdey).
Yrs. 9. Birthplace (Steta or Foreign Country) **Funeral** 1□ M 2****F Months Days Hours Director 212-22-7919 South Usual Residence of Decedent 10a. Stata 10h County 10c. City, Town or Location 10d. Insida City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director altimore Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda ò osedala St. Items 23a 21229

13. Was Dacedent of Hispanic Origin? (Spacify Yes or Noif Yas, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2 No 11. Marital Status 14. Rece Amarican Indian Bleck, White, atc. filed within 72 hours efter Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No If Yes, Giva Year or Detes Specify: Specify: Black by 3 Widowad 4 Divorced Completed 16e. Decadant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highast grade completed) permit. Pages 1 and 2 should be filed within Depertment of Haalith and Mental Hygiene. Important: If flam 27 is marked other then any Injury or other traumatic avant Elementary/Secondery (0-12) College (1-4or 5+) Cook 12 Head 18. Mgther's Name (First, Middla, Meiden Sun 17. Father's Nama (First, Middle, Last) Eugene 19a Informant's Name/Ralationship (Typa, Print) 19b. Mailing Addrass (Street end Number of Rurel Route Number, City or Town, Stata, Zip Code) hard 20b. Place of Disposition (Neme of cemetary, crematory or other) hd. 20 On Method of Disposition 20c Removal from State 4 □ Donation 5 □ Other (Specify) Cem 21. Signature of Funarai Sarvice Licenses 22. Nama and Address of Fecility Service McCulloh 23a. Part1. Enter the disease, or complications that ceuse of death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or haart failure. List only one ceuse on each contract the mode of dying, such as cerdiac or respiratory arrest, shock, or haart failure. Approximata Interval Between Onset and Deeth **Physician** /Medical Immadiate Ceuse (Final Sepsis disease or condition resulting in deeth) week **Examiner** Due to (or as a consequence of): Small Bowel Obstruction weeks -transit ins that the death certificate be axecuted Sequentially list conditions, if eny, leading to immadiate ceusa. Enter Underlying Ceuse (Disaase or Injury that Initiated avants resulting in death) Last end Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medicai the Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertension þ 24b. Were autopsy findings available prior to Be Completed 24a. Was an autopsy performed? Rheumatoid Arthritic completion of ceuse of deeth? Scoliosis 1 Yes 2 No 25. Was cese referred to medical examinar? 26. Placa of Death (Check only one) 1 Yes 2 Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 27. Manner of Death 28c. Injury et Work? 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Division 5 Pending investigation 1 Naturel 2 Accident 1 ☐ Yas not Applicable 6 Could not be datermined 3 ☐ Suicide 28a. Place of Injury - At home, farm, streat, factory, offica building, atc. (Spacify) 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stata) To the Hospital or All within 24 hours after d To the Funeral Direct completely filled in by 4 Homiclde Medicai 29a. Cartifier Certifying Phyaician: To the best of my knowledga, daath occurred at the time, data and place, and dua to the causa(s) and mannar as stated.

[Insert Section 1] Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, deta end place, and due to the cause(s) and manner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

RES- 000

Park Avenue Apartment 405 North

March

Baltimore, Maryland

18,1997

21217

Registrar

DHMH 16 Rev 6/95

State

30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print)

1518

32. Registrer's Signature

1. Levidson-Randelle

Chang

MAR 1 9 1997

Tom

31. Date filed (Month, Day, Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

of Maryland / Department of He	alth and Mental Hygiene
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Examiner		ecility Neme (i	if not institution,	give street and n	um <i>ber)</i>				4b. City, Town, or L	ocation of Death	4c. County			
	2979 CORNWALL ROAD DUNDA							DUNDALK		BALT	OMI	RE		
Funeral	5. Sc	cial Security N	lumber 6	S. Sex	7. Age (In yrs.	last birthda) If Under Months	1 Year Days		8. Date of Birth (Month, Day,			plece (State or Fo	reigi
Director		20-38-		1 M 2 □ F	56	Yrs.	Wildright	Days	Trodis Will.	Mar.4,		Mary	land	
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Ith and Mantal Hygins It is marked other traumatic event, I To Be Co	19a. fnformant's Name/Reiatlonship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										ip Code)			
Department of Haaith Important: If Item 27 I any Injury or other try once.		Method of Disp I □ Burial 2 (I □ Donation	position	-	State 20b. I	esape	ake (Cre	all Rd. matory : ss of Facility Ashton I	3-19-97	Be1t	svil	le, Md	
sician edical		Pa II. Emar th shock, or haal		omplements that	caused the daat	2	134 V	Vil.	low Spr ng, such as cardiac	ing Rd.	, Dund			n
miner	dise	ase or condition Iting in death)		Нурел			terio	scl	erotic	Cardio	vascul	ar	Disease	
rial-transit	Sequ if any caus	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or Injury thet initiated events resulting in deeth) Lest b. Dua to (or as a consequence of): Due to (or as a consequence of):												
as the burial-transit	(LIGIT													
etached for usa as	Dort I	L Other claniti	loont oon dittore	d	looth hut and an			enerus.	and the Board	non Dida	h			- 41
			es Mel		leath but not res	ulling in the	undanying ci	ause gn	ven in Part I.				to the cause of de	
Completed by										24a. Was a perform	n autopsy ned? ECTION	8	Vara autopsy findir vailable prior to ompletion of cause f death?	-
M IO													□ Ves 2□ No	
123		25. Was case raterred to medical 26. Place of								1 ☐ Yes 2 ☒ No 1 ☐ Yes 2 ☐ No Deeth (Check only one)				

To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After

Division of

Theodore King M.D. 31. Date filed (Month, Day, Year)

MAR 1 9 1997

5 Pending investigation

6 Could not be determined

1 X Yes 2 □ No

27. Mannar of Death

1 Naturel

2 Accident

3 Sulcide

29a. Certifier (Check only one)

4 Homicida

29b. Signature end title of cartifier

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

O.C.M.E. MARCH 16,1997

30. Nama and address of parson who complated causa of daath (Itam 23a) (Type, Print)

28a. Date of Injury (Month, Day Year)

111 Penn Street, Baltimore, Maryland 21201

Other: 4 Nursing Home 5 X Residanca 8 Other (Specify)

28d. Describe how injury occurred

State Registrar

Medical Certification: To

32. Registrar's Signatura

Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

